Where We Stand

A Guide to OMA Policy Statements

Updated February 2026

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ACCOUNTABLE CARE ORGANIZATIONS

ACCOUNTABLE CARE ORGANIZATIONS PRINCIPLES

OMA adopts Accountable Care Organizations (ACOs) principles developed by the AMA See Appendix H *(June-12)*

ACCREDITATION/LICENSURE/CREDENTIALING

ADMINISTRATIVE SIMPLIFICATION

The OMA will continue to identify factors contributing to the administrative complexity in health care in order to reduce the administrative burden on physicians and their staff and increase the time spent with patients. *(June-12)*

CLINICAL OFFICE & LABORATORY ACCREDITATION (COLA)

OMA endorses the accreditation program for office laboratories of COLA. OMA will publicize information about COLA and encourage all physicians to seek clinical lab accreditation through COLA in lieu of federal certification and state licensure. *(A-95, Reaffirmed A-11)*

OMA reaffirmed its endorsement of the COLA program and was to publicize information about COLA and encourage physicians' use of COLA accreditation for CLIA compliance. In addition, OMA is to acknowledge its endorsement of COLA on its website with a direct link to COLA. *(I-99, Reaffirmed A-11)*

LASER TECHNOLOGY

OMA holds that the use of laser technology for purposes of removing or altering human tissue is the practice of medicine. *(I-92, Reaffirmed A-11)*

OMA supports a statutory definition of laser surgery as the practice of medicine. *(I-96, Reaffirmed A-11)*

LICENSURE, MEDICAL

OMA supports the Oregon Medical Board's Licensure Expedited Endorsement Policy which allows for qualified applicants who have practiced in other states to forego primary source verification of core credentials. *(A-72, Revised A-11)*

MAINTENANCE OF CERTIFICATION (2018-02)

1. The OMA supports the requirement of Continuing Medical Education (CME) and ongoing quality assessments of physicians in order to maintain society's trust in the self-regulation of the practice of medicine.

2. The MOC program not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

3. The OMA will continue to work with other stakeholders to provide alternatives to long-term recertification examinations. The alternatives should be relevant to practice and take into consideration the burden on and cost to physicians.

With regard to the United States Medical Licensing Examination:

1. The following recommendation shall replace current OMA policy around USMLE:

   That the OMA continue to support efforts to reduce trainee indebtedness by reducing the financial burdens of the standardized testing such as USMLE and COMPLEX examinations with specific focus to addressing the travel costs associated with Oregon trainees traveling to other states to complete clinical skills examinations by advocating for increased availability of local and regional testing centers. *(Feb.-18)*

MAINTENANCE OF CERTIFICATION (2018-06)

The OMA adopts the AMA Principles on Maintenance of Certification. *(June-18)*

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S.,

including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME. 1

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.

MEDICAL STAFF CREDENTIALING DATA

OMA supports the autonomy of hospitals and health plans to select appropriate and qualified data on providers which may include board certification status as one of the factors in the credentialing/privileging process. *(January-17)*

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

In the event that an HIV-infected physician demonstrates symptoms of cognitive compromise, he or she should be treated like any other distressed and/or impaired physician. Detection of and intervention on behalf of impaired physicians should remain the shared responsibility of the medical profession. *(A-91, Revised A-11)*

ADVERSE EVENTS

FORGIVING BILLS AND EXPRESSING SYMPATHY OR BEREAVEMENT

The Oregon Medical Association (OMA) has long counseled its members that forgiving a bill following an unexpected bad outcome is not an admission of liability and is entirely appropriate under the circumstances. This advice is based on the experiences of the OMA/CNA Physicians' Protection Program over the last thirty-seven years where time and again, patients who received a bill following an adverse event said this action was what drove them to a lawyer. In 2005, the Oregon Legislature passed an OMA-created bill to enable physicians to express sympathy or bereavement following an unexpected bad outcome. Together, these two efforts place the needs of patients first at a key time in the course of medical care.

OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS (OAHHS) GUIDELINES FOR NON-PAYMENT FOR SERIOUS ADVERSE EVENTS

For the reasons above, the OMA endorses the approach recently taken by OAHHS in adopting its Guidelines for Non-payment for Serious Adverse Events. OMA welcomes these guidelines since patients often receive care from members while they are hospitalized, and coordinating policies on non-payment reinforces a message both organizations strongly support.

ONLY RESPONSIBLE PARTY SHOULD WAIVE CHARGES

In a situation where care is jointly delivered, OMA believes that only the individual or entity determined to be responsible for the event should waive their charges and forego additional charges directly resulting from the occurrence.

PROCESS FOR MEDIATING DIFFERENCES

To that end, OMA and OAHHS, together with organizations that insure physicians and hospitals, have established a voluntary mediation process through OMA's Professional Consultation Committee to address differences that arise concerning roles and responsibilities in these situations. It is the goal of our respective organizations to encourage access to this process when and where needed. We believe all of these steps are an affirmation of the importance that OMA and OAHHS place on our members' relationships with patients and their families. *(A-08)*

ADVERTISING

AMA GUIDELINES

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, e-mail or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

The communication may include: (1) the educational background of the physician; (2) the basis on which the fees are determined (including charges for specific services); (3) available credit or other methods of payment; and (4) any other non-deceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations, which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention.

For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimonial's condition generally receive.

Objective claims regarding experience, competence and the quality of the physician's services may be made if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards that apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, internet, radio or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to

have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those, which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. *(I-92, Revised A-11)*

TELEPHONE LISTINGS

1. WHITE PAGES

    a. Physicians - the names of the physicians in the alphabetical section shall meet the requirements of the Doctor Title Law (ORS 676.100), and may include specialty of practice, telephone company policy permitting.

    b. Clinics or professional corporations - the assumed clinic or Professional Corporation name shall be identified by the requirements of the Doctor Title Law.

2. CLASSIFIED YELLOW PAGES
    a. Physicians - the purpose of physician listing in the classified section of the telephone directory is to provide the public easy access to a complete listing of physicians and their telephone numbers in a given community. The responsibility for proper listings in the telephone directory rests upon the individual physician. Telephone companies are not expected to enforce ethical standards, but will offer assistance in advising physicians of legal and ethical requirements when appropriate.

    b. Clinics and professional corporations - the names of medical clinics should be listed under the category heading "Physicians and Surgeons - M.D. - Group, Association and Corporate Practice," which would follow the alphabetical listing of all physicians. *(I-74, A-83, Reaffirmed A-11)*
    Adopted at the interim House of Delegates, 1974.
    Amended at the annual House of Delegates, 1978.
    Amendments adopted in1978 rescinded and original guidelines adopted in 1974 retained as policy - adopted at the annual House of Delegates, 1983.
    Reaffirmed at the annual House of Delegates, 2011.

ALLIED HEALTH

MEDICAL ASSISTANTS

OMA encourages all Oregon physicians' medical assistants to join the American Association of Medical Assistants (AAMA) and its state/local chapters, as OMA commends the objectives and efforts of this organization. *(I-72, Reaffirmed A-11)*

OMA supports education of the general public that medical assistants assisting physicians in patient care are a part of the larger physician extender group, working directly under the supervision of a duly licensed physician and responsible only to that physician, performing any duties requested by that physician. *(I-77, Reaffirmed A-11)*

OMA supports medical assistants as highly valued office personnel, and that OMA physician-employer members support the professionalism of medical assistants by encouraging continuing education and membership in their professional societies. *(I-94, Reaffirmed A-11)*

MEDICAL PRACTICE; SCOPE OF

OMA advocates for public policies that ensure all health care providers do not legislate or regulate their scopes of practice beyond their education, training and documented competence.

OMA supports the AMA's Ethical Guidelines policy on Scope of Practice:

1. It is ethical for physicians to work in consultation with or employ allied health professionals as long as they are appropriately trained and duly licensed in Oregon to perform the activities being requested.

2. Physicians have an ethical obligation to the patients for whom they are responsible to ensure that medical and surgical conditions are appropriately evaluated and treated.

3. Physicians may teach in recognized schools for the allied health professionals for the purpose of improving the quality of their education. The scope of teaching may embrace subjects which are within the legitimate scope of the allied health professional and which are designed to prepare students to engage in the practice of the professional within the limits prescribed by law. *(A-98, Revised A-11)*

ANTITRUST GUIDELINES

OMA adopted a set of antitrust compliance guidelines for use by all OMA committees and distribution to all component societies. This document is available upon request. See Appendix E *(I-90, Reaffirmed A-11)*

ATTORNEY - PHYSICIAN RELATIONSHIPS

OMA adopted the "Oregon Medical Association/Oregon State Bar Association Rules of Conduct Governing Attorney-Physician Relationships" and approved the document as official OMA policy. This document is available on request. See Appendix F *(A-83, Reaffirmed A-11)*

BALLOT MEASURES

2018 BALLOT MEASURE 105 – FEDERAL IMMIGRATION ENFORCEMENT

The OMA opposes passage of 2018 Ballot Measure 105 to repeal the sanctuary state law initiative which limits the cooperation of local law enforcement with federal immigration enforcement. (*Sept. 2018*)

2020 BALLOT MEASURE 109 - OREGON PSILOCYBIN SERVICES PROGRAM

The OMA opposes the 2020 Ballot Measure 109 which would require the Oregon Health Authority to establish the Oregon Psilocybin Services Program. *(Sept. 2020)*

CANCER

OMA affirms its support of appropriate cancer screening based on evidence based studies. *(A-88, Revised A-11)*

CHILD/ADOLESCENT HEALTH

ACCESS TO VIOLENT VIDEOS

OMA supports state and national efforts to restrict access of minor children to violent video games in public places. *(I-00, Reaffirmed A-11)*

ADDRESSING THE CRISIS IN YOUTH MENTAL HEALTH IN OREGON

The OMA supports an awareness campaign on the crisis of youth mental health and substance use, and risk for suicide, with Oregon legislative representatives, physicians, and physician assistants.

The OMA recommends a review of the state study on whether mental health parity is being fully implemented in Oregon.

The OMA supports improved state and federal funding dedicated to ensuring all youth, from infancy to transitional age youth, can access evidence-based mental health and substance use screening, diagnosis and treatment to appropriately address their needs, with particular emphasis on meeting the needs of under-resourced populations.

The OMA promotes the adoption of effective and financially stable mental health care in primary care pediatrics and family practice, including clinical strategies and effective models of payment. (*Feb. 2022*)

ADVERSE CHILDHOOD EXPERIENCES

The OMA recognizes that adverse childhood experiences (ACEs) have a significant association with many physical and medical conditions, and with future employment and educational attainment. Medical schools, residency training programs, and continuing medical education programs are encouraged to incorporate education on the prevention, recognition, and intervention of ACEs.

The OMA adopts and supports the AMA's Adverse Childhood Experiences and Trauma-Informed Care Policy:

a. Evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. Evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. Efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;

d. Efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. Funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life. *(Sept. 2020)*

ANTISOCIAL BEHAVIOR

OMA supports state and local endeavors, including legislation, that would stimulate programs to identify signs of aggressive and antisocial behavior, including bullying, in children as reasonably possible, and that adequate and appropriate early interventional and referral resources be provided to parents, teachers and school systems by state and local entities as a means to modify at-risk behavior. *(I-98, Revised A-11)*

CHILDREN'S PROGRAM

OMA endorses the basic concept and scope of services to be provided under the Oregon Healthy Kids Program as an important first step in meeting the unmet health needs of our state's children. Furthermore, OMA endorses the inclusion of infants who have required neonatal intensive care. *(I-01, Reaffirm A-12)*

OMA encourages its physicians caring for mothers and children to be advocates for parental participation in the voluntary screening process available both prenatally and around birth through the Oregon Healthy Kids Program. *(A-02, Reaffirm A-12)*

DRIVERS' LICENSES

OMA supports the State of Oregon's adoption of the Graduated Driver's License program. *(A-98, Revised A-11)*

NEED FOR INCREASED SLEEP

OMA supports the development of an educational campaign designed for local school districts explaining the need for more sleep during adolescence than during childhood, the shift to a later sleep pattern in adolescence and the impact of inadequate sleep on driving safety and school performance. *(A-98, Reaffirmed A-11)*

PARENTAL LEAVE

OMA shall advocate for the development of paid maternity parental leave programs in Oregon through advocacy. *(June-17)*

PHYSICALS

It is OMA policy to endorse adoption of the "Suggested Exam Protocol for the Physician," "Model Physical Exam Form," "Model School Sports Pre-participation Examination" and "Model School Sports." *http://www.kidsports.org/doclib/PhysicalExamination.pdf (A-93, Reaffirmed A-11)*

Pre-sports physical examinations for participation in school sports activities should be required by schools at Grade 7 and 10, or upon entry into the school system. *(A-93, Reaffirmed A-11)*

The Model Pre-participation Annual Interval History should be completed by parents of the athlete in each year a physical examination is not required prior to sports participation. *(A-93, Reaffirmed A-11)*

SCHOOL HEALTH

OMA endorses the American Academy of Pediatrics Guidelines for Health Supervision of Children and Youth as an appropriate periodicity schedule for children's and adolescents' physical examinations. *http://brightfutures.aap.org/pdfs/Guidelines_PDF/1-BF-Introduction.pdf*

Because school-based physical assessments were originated at a time when many schoolchildren had little or no access to routine health supervision by a qualified physician and because comprehensive health screening is seldom available in schools, parents should be encouraged to seek a source of continuing primary care for their children and adolescents. (*A-86, Reaffirmed A-11)*

OMA supports the concept of school-based health clinics and encourages physicians to participate in local efforts to establish them, recognizing that local autonomy regarding service choices should be respected and a good flow of information between providers and parents should be encouraged. *(I-90, Reaffirmed A-11)*

OMA supports the mission and objectives of school-based clinics and their continued long term funding in Oregon. *(A-91, Reaffirmed A-11)*

SEX EDUCATION

OMA encourages and supports the Oregon Department of Education's efforts to require effective sex education classes, with sex education curriculum including proven effective elements designed to prevent teen pregnancy, and sexually acquired diseases, and that teachers who teach this curriculum be trained to become proficient in its delivery. *(A-98, Revised A-11)*

RESTRICTING PERSONAL DEVICE USE IN OREGON SCHOOLS TO PROMOTE STUDENT MENTAL HEALTH AND ACADEMIC ACHIEVEMENT

The OMA supports recommendations that Oregon school districts prohibit the use of personal electronic devices by students from the start of regular instructional hours until the end of regular instructional hours, with the following exceptions:

A. When the student's medical provider orders use for the care and treatment of a medical condition.
B. When access and use are stipulated in the student's individualized education program, as defined in ORS 343.035 or an education plan developed for the student in accordance with section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794

Exceptions should be purpose-, time- and place-specific, away from where students congregate.

School districts should give serious consideration to students using school-protected electronic devices with these exceptions, when possible.
(October 2025)

STATUTORY RAPE, SEXUAL AND OTHER FORMS OF ABUSE OF MINORS

OMA encourages its members to meet their legal obligations to report statutory rape and sexual and other forms of abuse. Furthermore, OMA should join with the Oregon Attorney General and the Oregon District Attorneys Association to seek legislation to facilitate the reporting by health care providers of statutory rape, the prosecution of adult males who impregnate minor children

and encourage district attorneys to make such prosecution a high priority. *(A-98, Reaffirmed A-11)*

TEEN PREGNANCY

OMA should play an active role in efforts to reduce the teen pregnancy rate in Oregon by urging its members to work with local school boards to educate parents and adolescents about the health risks associated with teen pregnancy; to involve themselves in discussions with local school boards about programs and information offered to students regarding adolescent sexuality and teen pregnancy; and to act as resources of information for sexuality and health issues.

OMA supports the continued funding of school based health centers to provide contraceptive counseling, examinations and supplies. *(A-95, Revised A-11)*

DRONES

The OMA supports appropriate legislation, regulatory, and/or legal action requiring protection of patient rights with regards to private party drone usage by the establishment of drone-free zones around health care facilities. *(October 2016)*

ETHICS

PREAMBLE: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence or who engage in fraud or deception.

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services.

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

PREAMBLE: The Oregon Medical Association encourages members not to exploit the special physician-patient relationship in any manner whatsoever.

Physician-Patient Relationship:

1. Consistent with this preamble and the ethical guidelines of the American Medical Association, it is not unethical for a physician to dispense diets, vitamins and other health care products provided there is no exploitation of the patient.

2. Consistent with this preamble and the ethical guidelines of the American Medical Association, the physician should not recommend such health products when he is influenced by his direct or indirect financial interest in the enterprise supplying such products.

3. Consistent with this preamble, the physician should not use his office, clinic or hospital for the purpose of selling products or services that are not a part of the administration of medical care.

4. Consistent with this preamble, the physician should not use the physician-patient relationship to influence patients to buy or sell products or services, which will result in financial gain for the physician. *(A-79, A-82, I-82, Reaffirmed A-11)*

Adopted the AMA Principles of Medical Ethics at the interim House of Delegates, 1979.
OMA Ethics Committee instructed to develop standards of conduct - annual House of Delegates, 1982.
Adopted OMA ethics guidelines at the interim House of Delegates, 1982.
Reaffirmed at the annual House of Delegates, 2011.

GOVERNANCE

GENDER NEUTRALITY

OMA should assure that the Bylaws reflect gender neutrality, and gender neutrality in all OMA publications, documents and public statements be required. *(I-92, Reaffirmed A-11)*

ENSURING OMA ACCESSIBILITY FOR ALL MEMBERS

The OMA will study/review the needs and numbers of members living with disabilities as part of our ongoing membership recruitment, retention, and engagement, and report back annually to the BOT beginning in one year (Winter 2026 BOT meeting) and to the membership within 3 years.

The OMA will form an advisory group (composed at least in part of OMA members who themselves are living with or having lived with a disability) to promote inclusivity for physicians and medical students with disabilities in all OMA activities; to update OMA on advancements in technology that could further facilitate inclusivity and engagement; to identify or develop educational materials, resources, toolkits for members regarding accommodations for members (and patients/families) living with disabilities; and that would provide ongoing input related to the

planning and adaptation of all OMA events so that OMA members or guests living with permanent or temporary disabilities feel welcome, able, and encouraged to participate.

The OMA will partner with other organizations to advocate for updating, adhering to, and enforcing ADA and other local, regional, state, and federal regulations and requirements that ensure adequate access for people living with disabilities to public spaces, facilities, events, and other venues. *(February 2025)*

MISSION OF OMA

The mission of OMA is "to serve and support physicians in their efforts to improve the health of Oregonians." *(I-03)*

VALUES, OBJECTIVES AND CORE PURPOSES OF OMA

OMA adopts the values, objectives and core purposes as follows in keeping with the mission of serving and supporting physicians in their efforts to improve the health of Oregonians:

I. To establish and maintain high ethical, educational and professional standards, the OMA shall:

    a. Define and enforce the principles of medical ethics
    b. Provide judgment and correction of breaches of ethical and professional standards by physicians in the practice of medicine
    c. Encourage physicians to continually improve their knowledge and proficiency in medicine
    d. Provide institutional accreditation for continuing medical education
    e. Conduct review of professional liability claims against members

II. To provide benefits and services to aid members in their professional pursuits, the OMA shall:

    a. Sponsor and endorse group insurance programs
    b. Develop and conduct programs to reduce the incidence of professional liability claims
    c. Sponsor and conduct courses in practice management
    d. Provide methods and mechanisms to assist physicians in distress
    e. Provide business and professional services designed to assist members in their professional activities
    f. Work to keep Oregon physicians-in-training in the state upon graduation by promoting appropriate venues and networking

III. To enhance goodwill, cooperation and unity among physicians, OMA shall:

    a. Maintain an effective and democratic policymaking body (House of Delegates), representative of county and specialty societies
    b. Solicit membership from all styles of practice and philosophies; encourage participation and identify to all physicians and physicians-in-training, and physician assistants (PAs) the value of association membership
    c. Provide timely dissemination of information pertinent to medical practice

d. Research and disseminate to the membership socio-economic data relevant to medical practice
e. Provide assistance to hospital medical staffs in identifying staff issues and provide leadership in addressing such issues
f. Provide appropriate meeting facilities to enhance an atmosphere for camaraderie, social intercourse and cooperation among members
g. Conduct meaningful liaison with county and specialty medical societies
h. Maintain worthwhile and effective committees composed of members representing geographic and specialty interests
i. Recognize and reward physicians for exceptional leadership and productive participation in association and community affairs

IV. To vigorously advocate the public's and profession's interest in matters of health and medicine, the OMA shall:

a. The Government Affairs Department shall maintain an effective relationship with the legislature and other governmental agencies to achieve the goals of the OMA
b. Sponsor an effective political action program (OMPAC)
c. Continuously link with other organizations and institutions having an interest in health care and medicine, and coordinate the political activities of physician medical organizations throughout the state to achieve synergy in advocating for our patients and our doctors
d. Encourage members to actively participate in the affairs of their communities
e. Enhance the health of the public by improving public health policies and practices
f. Work with public health professionals and agencies to improve and ensure the health and well-being of all Oregonians
g. Take an active leadership role in the area of patient safety

V. To promote and defend the physician's freedom to practice medicine in the patient's best interest and to the patient's best advantage, the OMA shall:

a. Provide individual consultation to its members
b. Serve as a resource to members in evaluating alternative methods of medical care delivery and the ramifications of participation in such systems
c. Develop and implement effective public relations programs *(I-03, Revised A-11)*

OMA reasserts its commitment to upholding its values as outlined within Where We Stand to its constituents and the broader Oregon community and further commits to communicating to its constituents and the Oregon public its stance on ongoing major changes in health policy in a timely, accessible, and transparent fashion, using means such as the OMA website, email, and social media outlets. (June-17)

OREGON MEDICAL POLITICAL ACTION COMMITTEE

OMA reaffirms its support for the Oregon Medical Political Action Committee (OMPAC) and further dedicates itself to the continuation and growth of the medical political action movement in Oregon. Members are strongly encouraged to support OMPAC through annual contributions. *(I-81, Revised A-11)*

ORGANIZED MEDICINE

OMA encourages "physician affiliation at all levels of organized medicine county, state, national and specialty." *(I-87, Reaffirmed A-11)*

OMA POLICY AND SUPPORT FOR STATE AND FEDERAL LEGISLATION

The OMA reaffirms its current policy that the Association should adhere to the existing sunset mechanism to review policy actions older than 10 years, with periodic reports from the *Where We Stand* Task Force or an appropriate governance committee to the Speaker; that outdated position statements are of historical interest and should be included in OMA's *Where We Stood* document; that while the Association's support or opposition to individual legislation is not a matter of permanent policy, its position on legislation should be noted either in *Where We Stand* as a footnote to the appropriate policy position or referenced in other historical Association records; and that while Association policy may indicate a position on state or federal legislation, the Association's support or opposition to specific legislation does not lead to permanent support or opposition of state or federal law. *(Feb.-18)*

OMA SUB-ORGANIZATIONS AND OMA COMMITTEES

Being a membership driven organization, OMA and specifically the Executive Committee, should attempt to achieve a wider level of input from sponsoring OMA sub-organizations and from OMA committees before final decisions about the disposition of policy recommendations approved or referred by the Board of Trustees are made. *(I-03, Revised June-12)*

POLICY - OMA

OMA affirms the contents of these documents, *Where We Stand – A Guide to OMA Policy and Where We Stood – A Historical Guide to OMA Policy,* represents official and former OMA policy, respectively. Further, OMA provides that all policy is subject to review at any meeting of OMA. Such policies, however, shall be subject to automatic review 10 years from the date of their original adoption, reaffirmation, or revision.

OMA should reference its policies by a topic system reference by the action taken similar to the AMA Policy Compendium.

OMA should adhere to the sunset mechanism to review policy actions older than 10 years with reports from the Where We Stand Task Force to the of the Speaker.

OMA should make *Where We Stand – A Guide to OMA Policy and Where We Stood – A Historical Guide to OMA Policy* available to all members on OMA website. *(A-01, Reaffirmed A-11, Revised June-12)*

TELECONFERENCING

OMA will continue to offer a variety of teleconferencing options to facilitate participation by OMA members throughout the state. *(I-02, Revised A-11)*

WEBSITE

OMA shall maintain an electronic forum in the "members only" section of OMA website in which physician members are strongly encouraged to share information regarding practice and professional issues. *(A-00, Revised A-11)*

DISTRIBUTION OF MEMBERSHIP CONTACT INFORMATION

OMA obtains personal and professional membership data for purposes of enhancing communication within the organization. Only data authorized by the individual members will be distributed to the membership roster, the AMA, component and medical societies. Email addresses will not be distributed under any circumstances unless directly authorized by the member.

OMA will sell mailing lists of its membership in hard copy form or electronic (exclusive of email addresses) only to mailing houses for requesting third parties, provided the purpose of such mailing is deemed to be of interest and relevance to the membership. Distribution of mailing lists to members or sales of such lists to third parties will be done only after recipient has agreed in writing that such lists will be used for no other purpose than for that agreed to, and in the case of third parties, may be used only once. *(A-05)*

HEALTH CARE ACCESS

UNIVERSAL HEALTHCARE AND HEALTH COVERAGE - 2018

1. The OMA adopts the following policy statements:

Universal Healthcare and Health Coverage

All Oregonians should have healthcare that addresses the most important causes of death and disease, including health promotion measures, disease prevention, acute and chronic treatment, rehabilitation, and palliative care. Oregonians, through their elected officials, and with the guidance of their physicians, should determine the extent and quality of healthcare goods and services available to all, consistent with the combined goals of improving individual and community health.

Patients with health insurance have improved access to healthcare goods and services and better health outcomes. Health coverage should be readily identifiable, consistent across communities and populations, affordable, and portable, allowing patients to access care regardless of personal circumstance or employment. Oregonians, through their elected officials, should establish sustainable healthcare financing, administration, and payment systems that limit patient financial hardship and uncertainty, and support the physician practice of medicine.

2. The OMA adopts the following principles regarding Universal Healthcare and Health Coverage:

Health and Healthcare

Number 1. Individual health and longevity result from a combination of genetics, personal history and habits, culture, access to healthcare, education, and social and economic status (Social and economic determinants of health).

Number 2. The patient and society share responsibility for addressing the social and economic determinants of health, and hence, share responsibility for individual health outcomes.

Number 3. Society benefits from a healthy population: Individuals with dependable access to physical and mental healthcare live longer lives that are more productive.

Number 4. Society should ensure access to timely, effective and affordable care for mental and physical health problems.

Number 5. Society should regulate and reform the healthcare system through a public and transparent process that reflects a consensus of social values and balances the needs of the individual and the community.

Healthcare and Health Coverage

Number 6. All members of society should have health coverage that provides access to effective acute and chronic treatment of mental and physical illness, disease and injury (Universal Health Coverage).

Number 7. Society should prioritize coverage for healthcare services as necessary, using the best available medical evidence of efficacy and benefit in an effort to maximize individual and population health.

Number 8. Physicians, as stewards of the healthcare system, should provide ethical, evidence-based, cost effective medical care that respects the values of the patient and society.

Number 9. Financing for Universal Health Coverage is a shared public and private responsibility.

Number 10. Health coverage financing must be economically feasible, explicit, and sustainable.

Number 11. The structure and financing of the healthcare system should minimize individual patient responsibility for the cost of medical treatment; excess personal cost is a barrier to timely medical care and decreases health outcomes.

Number 12. The structure and financing of the healthcare system should minimize the personal stress associated with the cost of treatment, delinquent medical bills, and potential bankruptcy; financial hardship and economic stress diminish life expectancy.

Number 13. The structure and financing of the healthcare system should allow individuals the freedom to purchase additional services or insurance.

Administration of Healthcare and Health Coverage

Number 14. The patient and their personal physician, working together, should make decisions on the most appropriate medical treatment or intervention for a given health condition.

Number 15. The healthcare system must ensure a sufficient network of services and providers to improve patient health.

Number 16. Health coverage and benefits should be standardized, predictable, and readily identifiable by patients and providers.

Number 17. Simplification of healthcare administration and management reduces costs, enhances patient access to treatment, and improves the practice of Medicine.

Number 18. Healthcare coverage should be portable, consistent, and persistent, minimizing administrative delays in accessing medical care.

Number 19. Charges and payments for medical care at all levels should be predictable, transparent, and readily identifiable by patients and providers.

Healthcare Workforce

Number 20. Physician-led healthcare provides the best patient outcomes.

Number 21. The structure and financing of the healthcare system should encourage continued physician development and participation, thereby ensuring an adequate network of care.

Number 22. The Medical Tort (Malpractice, Liability) System should provide predictable compensation to individuals harmed by negligent medical care through an efficient process that promotes continuous quality improvement and patient safety.

UNIVERSAL HEALTHCARE AND HEALTH COVERAGE - 2024

The Policy, Legislative, and Justice Equity Diversity and Inclusion (JEDI) Committees collectively through a Universal Access Workgroup recommend the OMA adopt the following revised policy statement and place in Where We Stand:

Universal Healthcare and Health Coverage

All Oregonians should have healthcare that addresses the most important causes of death and disease, including health promotion measures, disease prevention, acute and chronic treatment, rehabilitation, and palliative care. Oregonians, through their elected officials, and with the guidance of their physicians, should determine the extent and quality of healthcare goods and services available to all, consistent with the combined goals of improving individual and community health.

Patients with dependable access to healthcare enjoy better healthcare outcomes. To facilitate access, health coverage should be readily identifiable, consistent across communities and populations, affordable, and portable, allowing patients to access care regardless of personal circumstance or

employment and with minimal administrative complexity. Oregonians, through their elected officials, should establish sustainable healthcare financing, administration, and payment systems that minimize patient and family financial hardship and uncertainty, and support the best practice of medicine.

That the OMA adopt the following revised principles regarding Universal Healthcare and Health Coverage into Where We Stand:

Health and Healthcare

Number 1. Individual health and longevity result from a combination of genetics, personal history and habits, culture, access to healthcare, education, and social and economic status (Social and economic determinants of health).

Number 2. The patient and society share responsibility for addressing the social and economic determinants of health, and hence, share responsibility for individual and community health outcomes and reduction of health disparities.

Number 3. Society benefits from a healthy population: Individuals with dependable access to physical and mental healthcare live longer lives that are more functionally independent and productive. Even a small segment of the population lacking access to health information and care can have a negative impact on the population at large.

Number 4. Society should ensure ease of access to timely, effective, affordable, and equitable care for mental and physical health problems.

Number 5. Society should regulate and reform the healthcare system through a public and transparent process that reflects a consensus of social values and balances the needs of the individual and the community.

Healthcare Access

Number 6. All members of society should have access to healthcare that provides timely, effective, affordable, and equitable acute and chronic treatment of mental and physical illness, disease and injury.

Number 7. Society should prioritize providing coverage for healthcare services as necessary, using the best available medical evidence of efficacy and benefit in an effort to maximize individual and population health.

Number 8. As stewards of the healthcare system, physicians and physician assistants should have the responsibility to provide ethical, evidence-based, cost-effective medical care that respects the values of the patient and society.

Number 9. Financing for Universal Health Coverage is a shared public and private responsibility.

Number 10. Health coverage financing must be economically feasible, explicit, and sustainable.

Number 11. The structure and financing of the healthcare system should minimize patient cost-sharing at time of care. Financial barriers at time of need discourages timely access and compromises health outcomes.

Number 12. The financial structure of the healthcare system should minimize the complexity and obscurity associated with the accounting and billing aspects of patient treatment. Delinquent medical bills, duplicate billings, and potential bankruptcy are significant stressors. Financial hardship and economic stressors worsen quality of life and life expectancy.

Number 13. The structure and financing of the healthcare system should allow individuals the freedom to purchase additional services or insurance.

Administration of Healthcare and Health Coverage

Number 14. The patient and their personal physician and care team, working together, should make decisions on the most appropriate medical treatment or intervention for a given health condition.

Number 15. The healthcare system must ensure a sufficient network of services and clinicians to provide care and improve patient health.

Number 16. Health coverage and benefits should be standardized, predictable, and readily understandable by patients and clinicians.

Number 17. Healthcare administration management should be simplified to reduce costs, enhance patient access to treatment, and improve the practice of Medicine.

Number 18. Healthcare coverage should be portable, consistent, and persistent, minimizing administrative delays in accessing medical care.

Number 19. Charges and payments for medical care at all levels should be predictable, transparent, timely, and readily understandable by patients and clinicians.

Healthcare Workforce

Number 20. Physician-led team health care results in the best patient outcomes.

Number 21. Potential improvement in overall patient outcomes can be achieved by a workforce (physicians and healthcare workers) which more closely matches the diversity of the population served. The healthcare system should recruit, educate and retain a diverse professional workforce that reflects the racial, ethnic and gender composition of the communities it serves.

Number 22. The structure and financing of the healthcare system should encourage continued physician education and training, thereby ensuring an adequate network of care.

Number 23. The Medical Liability System should provide predictable compensation to individuals harmed by negligent medical care through an efficient process that promotes continuous quality improvement and patient safety.

See Appendix Y
(June 2024)

ACCESS TO HIGH QUALITY EVIDENCE-BASED COST-EFFECTIVE HEALTH CARE

The OMA in order to ensure that all Americans will have access to high quality, evidence-based and cost-effective health care urges the Oregon Congressional Delegation and the US Congress to enact comprehensive health system reform after ensuring an honest, full, and fair debate of the options. This debate should include the advantages and disadvantages of Single-Payer, Medicare-for-all, and pluralistic systems. *(A-09)*

HEALTH CARE ACCESS – DEFINED

Health care access must be defined as a greater problem than lack of insurance or under-insurance. “Insured” does not equate to access for patients on Medicare or Medicaid who unable to establish a primary care provider relationship or any patient where there is a lack of physicians. *(A-06)*

INSURANCE COVERAGE OF INFERTILITY TREATMENT AND FERTILITY PRESERVATION IN OREGON

The OMA recognizes that infertility diagnosis, infertility treatment, family-building interventions, and fertility preservation services as essential components of reproductive health care and as such, the OMA shall advocate for public policies that support increased access to, and medical benefit coverage for, these reproductive health care services. *(February 2025)*

DEFINITION OF HEALTH EQUITY

The OMA advocates for the right to health equity. The OMA defines health equity as equitable access to health and healthcare, independent of race, nationality, ethnicity, sex, sexual orientation, gender, gender orientation, disability/ability status, primary language, income, socioeconomic status, age, education level, geographic location, and/or residency status, or any other identity or group identification that has or can be used as a reason for inequitable health care access, quality, or health outcomes.

The OMA’s advocacy for health equity encompasses access to care, quality of care, and health outcomes, ensuring that no individuals are prevented from attaining their highest level of health. Addressing health equity calls for a collective effort from society at large, policymakers, public health organizations, and healthcare systems. It's essential to confront and rectify avoidable health disparities, acknowledge and redress historical and present-day injustices and inequities, and actively work to prevent the emergence of new disparities in health and healthcare. *(October 2024)*

HEALTH CARE CRISIS IN OREGON

OMA to publish workforce report and officially and publicly notify our State Chief Executive and our Legislature of our grave concern about an impending health care crisis in the State of Oregon. *(A-04)*

IMPROVING DIALYSIS ACCESS IN OREGON

The OMA partners with external stakeholders to request state legislation or regulatory approaches tasking the Oregon Health Authority to study and provide recommendations to address the issue of improving access to dialysis services statewide. *(Feb. 2023)*

MEDICALLY INDIGENT

OMA policy for health care to the medically indigent is:

1. Health care delivery systems must feature equality of access for all persons at all economic levels.

2. Delivery of health care should be affected by individual private practitioners or organized medical groups so situated as to make complete health care available to all segments and economic levels of the population.

    a. “Organized groups” include closed panel clinics, producer cooperatives in various forms, health foundations and prepaid service plans.

    b. In circumstances where it is apparent that the traditional methods of delivery do not reach the target population, the medical profession is prepared to work with the public sector in developing and implementing experimental and innovative delivery systems designed to overcome identified obstacles.

3. Government participation in funding of health care delivery must recognize a pluralistic system to allow a patient the choice of the delivery system that best meets his needs, and government funds must be available for total purchase or partial supplementation in meeting the cost of complete health care when the income level of a family falls below established minimum criteria.

4. All types of health care delivery systems must, to the greatest degree possible, be locally developed and controlled with peer review coming from within the local professional group. *(A-71, Reaffirmed A-11)*

MEDICALLY NEEDY

OMA should support component societies in assuming leadership roles in the development of creative and innovative approaches for providing medical services to the medically needy, including the support of private local initiatives which attempt to assure the availability to quality medical care of the medically needy.

OMA should commit its staff and committee resources to constructively participate in public initiatives analyzing the current reimbursement system for welfare recipients with the continuing goal of providing the best quality medical services for Oregonians regardless of their ability to pay.

OMA should address proposals such as vouchers, co-payments, tax credits for medical services, private health insurance for welfare recipients and equitable financial system to pay for medical services.

OMA endorses the findings and recommendations of the Governor's Commission on Health Care, which includes the following statement of mission and recommendations:

> The state of Oregon has an obligation to ensure access without excessive burdens to an adequate level of health care for all Oregonians. This obligation should be balanced by people's obligation to provide for their own needs. *(A-82, Revised A-11)*

It is OMA policy that society has a covenant to see that those who are uninsured have access to basic health care. *(A-03)*

DISABILITY POLICIES

Number 1 Definition of Disability

Principal 1: The OMA defines disability using the biopsychosocial model, which emphasizes the interplay between conditions of the body or mind and the environmental or structural context that limits an individual's complete participation in society.

Principal 2: The OMA recognizes that the current legal definitions of disability rely on a medical diagnosis to provide protection for, and obligate the distribution of resources to, individuals, and therefore are lacking. This current legal definition places the onus on the individual and may not fully acknowledge the possibility of impairment when no clear medical cause is found.

Principal 3: The OMA advocates that reasonable measures, both existing and novel, be implemented to support persons living with disabilities in achieving full and healthy lives that maximize their independence and integration into the community, and to enable clinicians living with disabilities to fully and safely participate in the profession.

Number 2 Patient-Related and Person-Centered Disability Policy

Principle 1: The OMA's commitment to providing universal health care access means no subset of people should be restricted in their access to health care, including those with all degrees of disabilities, including mild, invisible, and complex disabilities.

AMA Adapted Recommendations: Supporting Healthcare Access for People with Disabilities

1. Advocate to protect access to appropriate and affordable healthcare, including preventative screenings, for all people with disabilities, regardless of the degree of their disability, throughout their lives.
2. Advocate for the highest quality medical care for persons with disabilities, including supporting the autonomy and informed decision-making of patients and their designated medical proxies, parents, or guardians (as developmentally appropriate).
3. Support clinicians in attaining appropriate resources to care for patients with disabilities, including making their offices more physically accessible, including but not limited to requirements of consistent with the Americans with Disabilities Act and any applicable state laws; facilitating reasonable accommodation for patients with cognitive, intellectual, developmental, sensory, and neurodivergent conditions and promoting the use of telehealth and other digital health tools to increase accessibility to care in general.
4. Promote cooperation among clinicians, public health and human services professionals, and a wide variety of people with disabilities to identify gaps in care and implement priorities and quality improvements for the care of persons with disabilities.

Principle 2: The OMA recognizes that a key component of combating bias and reducing healthcare disparities among people with disabilities is training health professionals on disability healthcare topics. The OMA supports policies that establish and improve upon curricula related to disability healthcare for trainees and clinicians.

OMA Recommendations: Promoting Training, Education, and Competencies for Health Professionals that Increase Awareness of Bias and Improves Disability-Inclusive Care

1. Promote medical curricula that emphasize autonomy in medical decision making, while accounting for social and cultural preferences and decision-making processes unique to each person, in lieu of treatment plans that aim to merely fix, cure, or eradicate disabilities.
2. Promote training, within both medical education and continuing professional development, on recognizing and addressing clinician bias, including implicit bias, toward people with disabilities.

AMA Adapted Recommendations: Promoting Training, Education, and Competencies for Health Professionals that Increase Awareness of Bias and Improves Disability-Inclusive Care

3. Encourage clinicians and trainees to understand how variable presentations of complex functioning profiles in all persons with disabilities, including those with multiple co-morbid medical conditions, can influence diagnosis and treatment.
4. Advocate for medical education programs to:
    a. Implement a curriculum on the care and treatment of children and adults with a range of disabilities.
    b. Center their disability education on the social model of disability and acknowledge the continued role of ableism in discrimination against people with disabilities in healthcare settings.
    c. Establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
    d. Educate trainees and clinicians on how to provide and/or advocate for appropriate and accessible medical, social, and living support for patients with disabilities so as to improve health outcomes.
    e. Include people with disabilities as patient instructors and multidisciplinary health care providers (such as occupational and physical therapists) in formal training sessions and preclinical and clinical instruction for a holistic, patient-centered education.

Principle 3: The OMA actively supports government actions that provide adequate financial assistance and/or quality of life improvements for people with disabilities to increase health equity.

AMA Adapted Recommendations: Supporting Government Actions Promoting Health Equity for People with Disabilities

1. Advocate for legislative support and funding of health care facilities, University Centers for Excellence in Developmental Disabilities (UCEDDs), Leadership Education in Neurodevelopmental and Related Disabilities (LEND) programs, and other academic and research institutions whose primary mission is to meet the health care needs of persons with disabilities.
2. Support insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.

3. Support legislative changes to the Americans with Disabilities Act of 1990 that would educate state and local government officials and property owners on strategies for promoting access for persons with disabilities. Oppose legislation amending the Americans with Disabilities Act of 1990 that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

OMA Recommendations: Supporting Government Actions Promoting Health Equity for People with Disabilities

4. Advocate for increased resources for competitive, integrated, and supported employment services, as well as housing services to address health-related social needs and reduce health disparities for people with disabilities.
5. Advocate for people with disabilities to have the option to move to community living arrangements in lieu of institutionalization whenever applicable, and to receive services in the least restrictive environment appropriate to their needs and informed choice.
6. Support government actions that promote reduced exposure to evidence-based risk factors for certain disabling conditions.
7. Support government actions that preserve and enhance Medicaid eligibility, reduce administrative barriers, and ensure adequate funding for Home and Community-Based Services (HCBS), supported employment, and long-term services for persons with disabilities.

Number 3 Clinician and Learner Related Disability Policy

Principle 1 - Protections for Students and Trainees with Disabilities: The OMA recognizes that eliminating discrimination against health professionals with disabilities starts with medical education and residency training programs. The OMA supports policies that advocate for disability accommodations during both the interview and the training processes for medical and physician associate (PA) students, as well as residents and fellows.

Recommendations:

1. Reject discrimination on the basis of disability in graduate medical education (GME) residency selection and in medical and PA school acceptance.
2. Urge all training programs to create accessible and clearly stated “functional”, rather than “organic”, technical standards that emphasize what learners can do and provide clear information on how disability accommodations will be provided.
3. Encourage medical and PA schools, as well as residency programs, to proactively provide information about disability accommodations for all applicants, regardless of their perceived disability status.
4. Recommend that all medical training programs have a trusted, designated individual or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, state anti-discrimination laws, and available support services.
5. Recognize that denying reasonable accommodations not only harms learners with disabilities but also impacts future patient care. Thus, training programs must provide appropriate accommodations to support educational success.
6. Discourage GME programs from pressuring students to either hide their disability or to unwillingly disclose their disability status.

7. Ensure that testing entities follow ADA guidelines, specifically Section 36.309, which limits excessive or unnecessary documentation requirements for testing accommodations.

Principle 2 - Protections for Clinicians with Disabilities: To combat hiring practices that may be influenced by implicit or explicit bias against clinicians with disabilities, the OMA upholds Title I of the ADA, which prohibits discrimination against qualified individuals in all aspects of employment, including hiring, training, and termination, based on disability.

Recommendations:

1. Ensure that interviewing and hiring decisions for qualified clinicians are not impacted by disability status or the need for reasonable accommodations.
2. Recognize that employers must provide reasonable accommodations, and that perceived cost cannot be used as a justification for discrimination, as established by the ADA.
3. Promote understanding of ADA law to ensure compliance among employers and to empower clinicians with disabilities to understand their rights and protections.
4. Discourage harmful cultural norms in medicine that promote unsustainable working conditions and stigmatize individuals who need accommodations.
5. Advocate for inclusive training standards and support a respectful and collaborative professional culture that allows individuals with disabilities to practice medicine both safely and successfully, centering on the shared goal of excellent patient care.
6. Encourage the Oregon Medical Board to assess and improve its process for reviewing accommodation requests to reduce licensing delays. Additionally, encourage greater transparency regarding the range of available accommodations.
7. Ensure that evaluations of clinicians providing unsafe patient care are based on objective, evidence-based standards and are conducted by independent professionals trained in disability rights to prevent discrimination.
8. Discourage the use of minimum physical requirements unconnected to the essential functions of the job in job postings that either intentionally or unintentionally chill individuals with disabilities from pursuing those positions.

Principle 3 - Promoting Accessibility and Inclusion in Professional Spaces: The OMA supports the development of accessible facilities and conferences to ensure clinicians with disabilities have equitable opportunities for involvement compared to their peers without disability.

Recommendations:

1. Reduce barriers for clinicians to attend conferences, continuing medical education (CME), meetings, lectures and/or other educational and professional events by ensuring that reasonable accommodations are advertised and easily accessed.
2. Recommend that the OMA include a way to request accommodations for upcoming events/CME and clearly list available accommodations.
3. Advocate for equal access to hospital and educational facilities for clinicians with disabilities.
4. Support the use of innovative models for accommodation in medical and PA training and professional development to reduce barriers and promote inclusion at all career stages.
5. Create learning and work environments that foster belonging and acceptance for clinicians with disabilities.
6. Encourage research on disability accommodation(s) and patient outcomes for clinicians with disabilities.

See also Appendix AB
(October 2025)

HOMELESS VACCINATIONS AND SCREENING SERVICES

OMA recognizes a lack of adequate health care for the homeless population and advocates for the development of a statewide system of health care for this population, similar to the primary care medical home, and establishes measurable goals specific to the needs of this population, that will be tracked through this system. *(June-17)*

OPPOSITION TO PROVIDER TAX TO COVER MEDICALLY NEEDY

OMA opposes the concept of any form of a provider tax on physicians and other providers of health care to fund in whole or in part that societal responsibility, but rather such funding be derived from a broad-based source of revenue from the public. *(A-03, Revised October 13)*

PATIENT ACCESS TO VISIT NOTES

The OMA adopts the following general policy regarding patient access to visit notes:

The OMA should encourage physicians to provide patients access to their visit notes with the goal of greater patient engagement and involvement in their health and health care. *(October 2016)*

TELEMEDICINE

OMA Key Principles on Telemedicine:

1. Telemedicine services should follow evidence based care standards, when available, to ensure positive and safe outcomes. OMA should encourage state and national medical societies to establish guidelines for the standard of care of services provided through telemedicine.

2. Telemedicine should be provided in a coordinated model. Care should be provided in coordination with the patients' medical home and/or their treating physician(s).

3. A patient's medical history should be available at the time of the telemedicine service. Telemedicine services should be documented in the patient's medical record.

4. Reimbursement for services provided through telemedicine should be adequate for both provider and clinical site, including all originating sites.

5. Telemedicine should be provided by licensed health care professionals within the state or by providers in other states with Oregon telemedicine licensure status. Providers should practice within their scope of practice.

6. Telemedicine policies should abide by laws that address privacy and security of patient medical information. *(January-15)*

PROTECTING PATIENTS FROM IMMIGRATION ENFORCEMENT IN HEALTH CARE SETTINGS

The OMA advocates for and supports policy excluding all federal agents and officers pursuing immigration enforcement actions from health care settings (including parking lots). This is to protect patients, patient families, caregivers, healthcare workers and others as well as to prevent interference with access to both acute and chronic medical care meant to save lives, reduce suffering, and mitigate risks for all people served at healthcare facilities. *(February 2026)*

HEALTH CARE DELIVERY

HEALTH CARE DELIVERY

OMA shall communicate such a message of affirmation and advocacy on behalf of its values of diversity, inclusion, equity, and support to its constituent members, identifying marginalized groups; and renew its commitment to address and resolve inequities related to bias, prejudice, and intolerance based on nationality, race, ethnicity, religion, gender, socioeconomic status, sexual orientation, gender expression, or ability in the health care system that influence the well-being of its healthcare providers, health science and allied health students in our clinics, hospitals, and communities. *(Jan. 2017)*

CULTURAL COMPETENCE

The OMA adopted a set of principles related to Cultural Competence. See Appendix J *(June-12)*

ELECTRONIC HEALTH RECORDS / HEALTH INFORMATION EXCHANGE

The OMA adopted a set of principles related to Electronic Health Records (EHR) and Health Information Exchange (HIE). See Appendix D *(A-11)*

PERSON-CENTERED LANGUAGE IN MEDICAL RECORDS

The OMA supports the following policy statements on person-centered language in medical records: the Oregon Medical Association (OMA) endorses the use of person-centered, equity-focused language in medical records to reduce stigma, improve patient care, and promote health equity. By prioritizing the individual over their condition, clinicians can foster dignity, respect, and unbiased decision-making, aligning with our commitment to equitable, patient-centered care.

The OMA also supports the following principles on person-centered language in medical records:

Principle 1: Respect Patient Dignity

- Use person-first or identity-first language based on individual preferences to prioritize the patient over their condition.

Principle 2: Eliminate Stigmatizing Terms

- Avoid terms like “non-compliant” or “substance abuser.” Instead, document structural challenges, such as “Patient unable to attend due to lack of transportation.”

- Include context for health behaviors to focus on systemic challenges rather than assigning blame.

Principle 3: Reduce Bias Transmission

- Use neutral, objective language to prevent perpetuation of bias among care teams and ensure equitable treatment.

Principle 4: Promote Training and Education

- Train healthcare teams to recognize and avoid stigmatizing language, improving clinical decisions and patient outcomes.

Principle 5: Urge clinicians and institutions to adopt person-centered language in medical records
See Appendix Z
(*May 2025*)

PHYSICIAN BURDENS RELATED TO THE ELECTRONIC HEALTHCARE RECORD (EHR)

The OMA shall continue to advocate for meaningful policy changes in the medical community to reduce the clear adminstrative burden that current forms of EHR platforms and reporting obligations place on clinicians. *(Sept.-19)*

SEAMLESS DIGITAL INTERFACES FOR BEST CARE

OMA should advocate for the interoperability of electronic medical data platforms for the purpose of improving patient care in Oregon. *(June-17)*

ELECTRONIC PRESCRIPTION CANCELLATION

OMA to ask the AMA to collaborate with all stakeholders to develop, standardize and implement a mechanism to cancel prescriptions electronically. Additionally, the OMA supports the creation, standardization and implementation of electronic prescription cancellation from all EMR vendors and that these orders be accepted by pharmacies and pharmacy benefit managers. (*Oct.-17*)

OPPOSING THE CRIMINALIZATION OF MEDICAL CARE AND PHYSICIANS/PAs PROVIDING THAT CARE WITHIN THE SCOPE ACCEPTED STANDARDS FOR THEIR SPECIALTY

The OMA affirms that the government and other third-party interference in evidence-based medical care compromises the sanctity of the physician-patient relationship and undermines the provision of quality healthcare.

The OMA opposes any government regulation or legislative action which would criminalize physicians and physician assistants for providing evidence-based medical care within the accepted standard of care according to recognized professional practice guidelines and the scope of a physician's training and professional judgment.
(*Feb. 2022*)

PATIENT CENTERED MEDICAL HOME

The OMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home". See Appendix I *(June-12)*

PRIMARY CARE

OMA's definition of primary care is as follows:

1. Primary care is a type of medical care delivery provided by a physician, which emphasizes first contact care and assumes on-going responsibility for the patient in both health maintenance and therapy of illness. It is personal care involving a unique interaction and communication and includes the overall coordination of the care of the patient's health problems with the appropriate use of consultants and community resources.

2. The medical specialties of family practice, internal medicine, obstetrics and gynecology and pediatrics should be recognized as major, although not sole, components of the discipline, which, together with general practice, provide primary care to the American public.

3. It is recognized that other specialties practice primary care in a limited sense as defined above, but they are not usually regarded as primary physicians.

Such recognition should in no way be interpreted in legislation or otherwise as precluding the patient from having a free choice of physician, or of the way in which he/she enters the health care system. *(I-76, Reaffirmed A-11)*

RURAL HEALTH

OMA acknowledges ongoing long-term problems associated with medical practice in rural areas and works with state legislature, specialty societies, academic institutions and other interested parties to encourage policies that promote and sustain rural health care.

OHSU and other academic institutions involved in the training of physicians and advanced practice/midlevel providers are strongly encouraged to promote rural practice as a viable option to medical and other health care professions students through:

- admissions policies that consider the rural and underrepresented status of applicants
- thorough and positive required clinical experiences in community-based and rural settings
- clinical opportunities with underserved populations throughout training
- specific programs for students interested in rural healthcare such as the Oregon Rural Scholars Program
- maintenance of broad training representative of the scope of rural practice for student and residents
- development of fellowships and other advanced training in surgical and obstetrical skills for primary care residents

- Reduction of cost of attendance (ie scholarships, obligated loan forgiveness and loan repayment options) for students with rural practice intention
- Ensuring adequacy of primary care residency positions in Oregon
- Other appropriate measures and initiatives

OMA prioritizes elimination of payment bias for rural providers and hospitals under Medicare, Medicaid, and insurance payment plans. CCO and ACO payments and structures should not disadvantage rural populations, physicians or hospitals. Other proven incentives for establishing or maintaining a rural practice, such as rural provider tax credits, medical malpractice subsidy for rural primary care practice, enhanced payment for rural patient centered medical homes and other measures, should be developed, maintained or improved. *(A-88, Revised A-11, Revised April-13)*

SECOND OPINIONS

OMA continues to support the concept of a voluntary second opinion whenever suggested by a physician or desired by the patient. *(I-78, Reaffirmed A-11)*

TELEPHONE CONSULTATION CODES

OMA affirms support for CPT codes 99371-99373, evaluation and management codes designated for telephone calls by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals. Furthermore, OMA, through the AMA, seeks to obtain third party reimbursement for medical telephone codes that are reasonable, properly documented on the patient's chart and for which the physician has previously examined the patient. In addition, OMA urges the AMA to continue to work with Center of Medicare and Medicaid Services (CMS), third party payors and appropriate medical societies to establish criteria by which certain telephone calls would be considered separate services for payment purposes. *(I-97, Reaffirmed A-11)*

TRAUMA INFORMED CARE

The OMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

The OMA endorses the Substance Abuse and Mental Health Services Administration's (SAMHSA) six principles of trauma-informed care:

- Safety
- Trustworthiness & transparency
- Peer support
- Collaboration & mutuality
- Empowerment & choice
- Cultural, historical, & gender issues

The OMA recognizes that trauma-informed care is not a specific set of practices or procedures. It requires constant attention, caring awareness, sensitivity, and cultural change and on-going internal organizational assessment and quality improvements.

The OMA collaborates with other stakeholders to increase education and training for physicians, physician assistants and other health care providers to improve their ability to care for patients who have experienced trauma. *(Sept. 2020)*

URGENT CARE CENTERS

OMA encourages urgent care centers and other outpatient facilities offering episodic treatment of minor injuries and illness to systematically inquire if patients have an established relationship with another physician in the community and, in cases where referral for specialty treatment or inpatient admission may be indicated, to make every effort to consult with the patient's regular physician before making the referral. *(I-92, Reaffirmed A-11)*

HEALTH CARE FINANCING

CONTROL OF UTILIZATION AND COSTS

OMA supports the AMA recommendations on Prior Authorization and Utilization Management Reform Principles (Oct.-17)
See Appendix S

The OMA will actively oppose efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be expected to assure quality while achieving cost savings. *(A-06)*

Any programs intended to control utilization and cost of medical services place a high priority on the ongoing education of physicians and other health care providers and administrators, enhancing the relationship between the patient, the physicians and the health plan or any consultants or third parties with whom they contract. *(A-06)*

ECONOMIC IMPACTS OF HEALTH EQUITY

OMA urges the Oregon Legislature to establish a multi-professional, statewide task force to evaluate the impact of health inequity on the state's budget as it pertains to health care expenditures. The OMA formally recognize the need to address the social determinants of health to improve the health of all Oregonians, regardless of socioeconomic status, and to create downstream savings for the state’s budget. (Oct.-17)

RADIOLOGY PRIOR AUTHORIZATION PROGRAMS

OMA will charge the Health Care Finance Committee to make the issues of economic credentialing and prior authorization for imaging services required by some health plans a high priority. (A-06)

OMA physicians review criteria currently used by radiology prior authorization programs that is benchmarked against established clinical systems and develop guidelines as educational tools for physicians as well as a uniform standard of quality.

1. The OMA will review the criteria/guidelines used by the American Imaging Management (AIM) to assure that they are consistent with nationally endorsed American College of Radiology (ACR) guidelines.
2. If AIM guidelines are consistent with ACR guidelines that the OMA disseminate these to its members.
3. The OMA shall review processes used by AIM to identify policies and procedures that create undue administrative burdens for physician practices.
4. The OMA work collaboratively with its members and health plans in Oregon to persuade AIM to reduce administrative burdens of physician practices.
5. The OMA facilitate the flow of information used by AIM for prior authorization to radiologists to assure the most appropriate study is performed. (A-08)

LONG TERM CARE

OMA supports alternatives to nursing home care if they are appropriate in quality and do indeed decrease health care costs. *(A-80, Revised A-11)*

PAYMENT REFORM

The OMA adopted a set of payment reform principles to guide the OMA as payment reform models are debated and implemented in Oregon. See Appendix C *(A-11)*

PHYSICIAN REIMBURSEMENT - MEDICARE - RESOURCE BASED RELATIVE VALUE SCALE

OMA supports the policy of the American Medical Association concerning the Resource Based Relative Value Scale (RBRVS). *(A-95, Reaffirmed A-11)*

OMA encourages our Federal Congressional Delegation to join with other disadvantages states to secure parity and fairness in the distribution of Medicare dollars. (*A-04)*

The OMA encourages the appropriate funding of cognitive and case management services that will require the redistribution of resources currently allotted to pay for low risk diagnostic tests and procedures. *(A-06)*

SELF-ADMINISTERED DRUGS

OMA resolves to ask the AMA to request the Centers for Medicare and Medicaid Services (CMS) change the current rule on the determination of self-administered drugs (SAD) so that each route of administration is independently calculated to determine the 50% rule. *(A-04)*

SGR FIX

Health system reform must include replacing the sustainable growth rate (SGR) with Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by fair stable funding formula. *(June-12)*

STORE-BASED HEALTH CLINICS

OMA policy based on AMA policy that any individual company or other entity that establishes and/or operates store-based clinics should adhere to the following principles:

1. Store-based health clinics must have a well-defined and limited scope of clinical services consistent with state scope of practice laws.
2. Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.
3. Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by MD/DOs as consistent with state laws
4. Store-based clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
5. Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of practice provided by the clinic.
6. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.
7. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.
8. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.
9. Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care. (*A-07)*

PROVIDER TAX

1. That the OMA continues to strongly oppose any direct taxes or fees levied on physician and PA services, physician-owned facilities, or "pass-through" costs that shift the burden of Medicaid or health system financing onto individual practices;

2. That the OMA continue to evaluate support for the use of broad-based, uniform assessments or taxes on institutional providers (such as hospitals or Managed Care Organizations) as a means to generate state funds for federal Medicaid matching, provided that such funding mechanisms do not impose financial harm on physician practices or diminish access to care. These assessments should be developed in consultation with, and agreed to by, the entities being assessed, such as hospitals and managed care organizations. In that way, they reflect a negotiated, collaborative approach to Medicaid financing, rather than a unilateral tax burden imposed without input or consent;

3. That the OMA oppose any state or federal proposals that would restrict Oregon's ability to fund Medicaid, so long as such policies protect physician and PA sustainability and patient access;

4. That OMA collaborate with the AMA, state medical associations, and specialty societies to oppose unfair or targeted taxation of physicians and PAs and advocate for adequate, sustainable Medicaid funding through equitable public financing.

See Appendix AD
(October 2025)

HEALTH CARE PLANNING

OMA position on health planning is consistent with the AMA's "Statement on Voluntary Health Planning."

1. Health planning should be the primary function of a collaborative group of community organizations and interested individuals. While a variety of structural modalities may be considered to implement this function, the most common is the creation of an eleemosynary (charitable) organization by the community to be served. However structured and financed, this "health planning organization" should be created by the mandate of the community to address health needs and priorities in a structured fashion and should be legally incorporated to perform this function.

2. The planning organization must be representative of the community and have the active support and participation of the community to be served, including but not limited to, physicians. The proper mix of the participants should be determined by the community served and should be responsive to the needs of the community.

3. As an entity representing the community at large, the planning organization should exhibit the following characteristics: thoroughness, objectivity, integrity, sensitivity to the interests of the community, understanding of health care delivery systems and financing, and accountability to the community served.

4. The planning organization should assume an active, positive role in assessing community health and medical needs and should serve as the community's advocate in meeting those needs. The recommendations of the organization should be advisory and the responsibility for implementing those recommendations should rest with the institutions and entities most directly involved.

5. The organization should serve in an informational and educational role to the community-at-large on such issues as community health status, health care financing, health care costs and the availability of local health resources. Periodic reports should be provided to the community on these and other significant health care issues.

6. The size and scope of the geographic area to be served is best determined by the community residents, based on an analysis of such factors as population density, service area of health care institutions and practitioners, geographic and transportation considerations and should not be arbitrarily defined by existing political boundaries. Regional considerations involving two or more such local planning areas may best be coordinated through a consortium of the local planning organizations as appropriate.

7. The planning organization should function under a constitution and bylaws which, at a minimum, set forth: (a) the major objectives of the organization; (b) a locally accepted process for the election, selection and/or appointment of members to the governing body; (c) a mechanism to preserve accountability to the community-at-large for the recommendations and actions of the organization, recognizing the accepted principles of

confidentiality; and (d) a mechanism for ongoing evaluation of all aspects of the organization's service to the community.

8. Decisions regarding the employment of professional consultants and/or staff are properly those of the governing body of the local organization based on the scope of its activities and financial viability.

9. There should be a substantial commitment from the community-at-large to supporting and financing the operation of the planning organization. This commitment may be expressed through donations of public funds, private funds or general solicitation. Donations of time and expertise may be quite substantive and should be recognized equivalently as community contributions.

10. Government may provide supplemental funding in support of local health planning activities directed toward meeting locally determined goals and objectives. Such supplemental financial assistance from government sources should not be accepted without careful consideration of the obligations which may accompany it and a commitment to achieve sufficiency as early as possible.

11. The planning organization should encourage and promote the development of positive incentives to attain the objectives identified by the community and should not have regulatory authority or responsibilities.

12. The protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process, and therefore should not include the use of regulatory sanctions.

Exemption from the anti-trust laws should be sought for actions taken to implement recommendations of the planning organization, in furtherance of the objectives identified and approved by the community during the planning process. *(I-82, Reaffirmed A-11)*

HOME HEALTH SERVICES

OMA endorses cost-efficient and comprehensive in-home services including nursing care, medical social work, physical therapy, occupational therapy, speech pathology, nutritional counseling and homemaker/health aide services; and urges that physicians provide their patients with available information concerning home health services in their community, and assist home health agencies in the development of methods to improve and augment services. Physicians are encouraged to fully utilize the efficient and effective home health care delivery system. *(A-78, Reaffirmed A-11)*

HOSPICE / END OF LIFE CARE / DEATH & DYING

DEATH WITH DIGNITY

OMA changes its official position on the law from “opposed” to “neutral.” (Oct.-17)

OMA has historically opposed enactment of all legislation intending to change or codify Oregon common law on the care of dying patients, and supports the position that "death with dignity" is a part of the doctor-patient relationship. *(A-77, Reaffirmed A-11)*

For members with legal concerns on this matter, OMA recommends that physicians calling the association for advice be furnished a copy of ORS 97.050 - 97.090, and be advised that they seek legal counsel from their own attorneys or ask their patients to consult an attorney prior to executing the necessary document. *(I-77, Reaffirmed A-11)*

OMA supports the concept of hospice care, either physician directed or by consultation, including pain and symptom control, as another option for care for cancer patients and their families in our "freedom of choice" medical care system. *(I-81, Reaffirmed A-11)*

OMA adopted a set of guidelines for the use of physicians in the withdrawal of life-sustaining procedures from comatose patients. A copy of this document is available in OMA offices upon request of member physicians. See Appendix G *(A-84, Revised A-11)*

OMA educates its members as to the benefits of hospice for patients with life-limiting illnesses and their families; and supports efforts in local communities to promote public awareness of hospice and of hospice services by patients during their final days. *(I-94, Reaffirmed A-11)*

LEGAL DEFINITION OF DEATH

OMA, upon recommendation of the Public Policy Committee, adopted the Kansas definition of death:

> A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function, and, because of the disease or condition which causes, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and in this event, death will have occurred at the time these functions ceased; or
>
> A person will be considered medically and legally dead if in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to restore or maintain spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory functions are terminated and before any vital organ is removed for purposes of transplantation. *(I-72, Reaffirmed A-11)*

PALLIATIVE CARE

OMA has reviewed the literature and the opinions and recommendations of other medical organizations on the most effective contemporary techniques of the management of pain, suffering and other aspects of the end-of-life experience among terminally ill patients and the OMA continues to support an open and informed dialogue between physicians and their patients about end-of-life decisions, and an ability to continue to provide comfort, care and pain control. *(A-94, Revised A-11)*

OMA has established the following policies regarding the role of palliative care at the end of life:

1. Promote and promulgate the goal of good, competent and compassionate palliative care at the end of life among Oregon physicians;

2. Support the availability of hospice and related palliative care for all Oregonians;

3. Support and contribute to a consortium of agencies to further the goals of competent, compassionate care of the terminally ill, including education of physicians, other health care professionals and the community, development of guidelines, and networking;

4. Develop a resource guide and annotated bibliography for physician use, which draws on rather than duplicates the excellent references already available;

5. Recognize the possibility of public policy permitting physician-assisted suicide as an option for the terminally ill, but work to have the discussion occur only in the context of hospice and/or appropriate palliative care to ensure the best possible care;

6. Work to protect the role of the physician in providing palliative care and the confidentiality of patient-physician relationships in this process; and

7. That OMA position itself as a champion of expert, comprehensive and readily available palliative care to patients at the end of life, whether in the home, hospital, nursing home or critical care unit, encouraging the use of hospice services whenever possible. *(A-95) (Reaffirmed I-05)*

8. That the Oregon Medical Association strongly recommends that physicians discuss Advanced Directives with their patients. *(I-05)*

OMA supports and advocates for compassionate and competent palliative care at the end of life and, furthermore, acknowledges that medical efforts to eliminate irreversible and extreme pain and suffering at the end of life are an appropriate medical response that may result in hastening the patient's death. OMA acknowledges the patient's legitimate right to autonomy at the end of life, but does not accept the proposition that death with dignity may only be achieved through physician-assisted suicide. *(A-97, Reaffirmed A-11)*

PHYSICIAN ASSISTED SUICIDE (PAS)

The Oregon Medical Association does not approve of any legislation, which condones the deliberate act of precipitating the death of a patient, or confers upon that act the status of legality. *(A-73)*

This does not imply, however, that a physician using his or her best judgment should not allow a patient to die with dignity. *(A-83, Reaffirmed A-11)*

OMA neither affirms nor rejects AMA policy opposing the participation of physicians in the termination of a patient's life and neither endorses nor opposes the initiative seeking to decriminalize physician-assisted suicide. *(A-94, Reaffirmed A-11)*

OMA adopted the following policy positions with regards to the PAS statute:

1. Physicians should not be obligated by law to include a patient's diagnosis on a prescription.

2. Physicians should either personally dispense medications under the law or, with a patient's written consent, consult with a specific pharmacist and disclose the purpose of the prescription or prescriptions to the pharmacist.

3. "Pharmacist" should not be included in the statutory definition of "health care provider."

4. A physician's and consulting physician's evaluation of a patient's "capacity" is a sufficient statutory standard under the law.

5. The law should not be amended to mandate an additional psychiatric or psychological evaluation.

6. The law should be amended to specifically state that prescriptions under the Act are confidential.

7. A demonstration of residency should include a requirement that the person be domiciled in Oregon for a minimum of six months prior to making a request.

8. Consideration should be given to clarify that records collected by the Health Division and subsequently distributed to additional state or other governmental entities are specifically included under the law's confidentiality provision.

9. Creation of a statutory advisory committee to evaluate information collected by the Health Division is not necessary.

10. Modifications of the Act to permit institutions to discipline physicians or sanction them should be carefully evaluated. *(A-98, Reaffirmed A-11)*

OMA's position on the issue of physician assisted suicide – that it neither opposes nor supports it – is as adopted in May 1994. Its opposition to ORS Chapter 127.800.897 (Oregon's physician assisted suicide law) is as adopted in May 1997. OMA affirms its policy on death with dignity, legal definition of death and palliative care as stated. *(A-05)*

ADULT AND ELDERLY SUICIDE PREVENTION

OMA encourages suicide prevention programs for adults and elderly in Oregon, and encourages the Oregon Legislature to fund such prevention programs. *(January-17)*

HOSPITALS

ACCREDITATION

OMA supports the Joint Commission on Accreditation of Hospitals and Health Care Organization (JCAHCO) and its voluntary accreditation system for hospitals and has urged that the JCAHCO maintain its independence from unreasonable governmental and non-governmental influence. *(A-78, Reaffirmed A-11)*

Oregon AMA delegates should propose that all future JCAHCO recommendations be evaluated and tested prior to nationwide implementation, and that JCAHCO submit documentation that each recommendation and requirement will improve the quality of medical care, and adhere to the principle of cost containment. *(A-80, Reaffirmed A-11)*

EMERGENCY ACCESS, ON-CALL

OMA convene its Specialty Caucus to consider the problems of on-call coverage and emergency access, and report its findings and recommendations. *(A-04)*

MEDICAL STAFFS

OMA affirms it is the responsibility of medical staffs to serve, in reasonable rotation, those patients lacking patient-physician relationships who seek medical care from hospitals. (*I-78)*

Pertaining to legal representation, OMA encourages the medical staff of each hospital in Oregon to secure its own legal counsel for advice on matters of mutual concern to the medical staff and the hospital. Additionally, OMA offers assistance to medical staffs and component medical societies in obtaining legal counsel with special interest and expertise in this field.

OMA believes it is in the best interests of the citizens of Oregon and consistent with each hospital's staff bylaws, medical staffs continue to develop the criteria for, investigate, review and make recommendations concerning the granting, denial or renewal of medical staff privileges of all providers of medical care on behalf of, but subject to, the final authority of each of the hospital's boards of trustees. Physicians and medical staffs should retain the prerogative for credentialing of all those who provide medical care in hospitals as is given to them by their bylaws. *(I-83)*

OMA requests that the AMA adopt as policy its General Counsel's draft of Legal Status of the Hospital Medical Staff. This draft amplifies and embodies the concept that organized medical staffs be recognized as a separate legal entity and as an unincorporated association representing the collective professional responsibility of its individual members in the management and administration of medical care within the hospital. *(I-85)*

OMA adopted the following additional resolutions which affect hospital medical staffs*:*

OMA encourages hospital medical executive committees and/or medical staff bylaws committees to periodically review the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations (particularly during the medical staff bylaws amendatory process); and

OMA encourages hospital medical staff executive committees and/or bylaws committees to request their hospital boards of trustees to notify them and provide an opportunity for review of any proposed or impending changes in the hospital/corporate bylaws; and

OMA encourages hospital medical staff executive committees to advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations vis-à-vis medical staff membership; and

OMA should develop guidelines for appropriate and adequate physician profile information for medical staff reappraisal and reappointment purposes; and

OMA should also develop guidelines to assist medical staffs in the reporting, documentation and proper disclosure of physician profile information. *(A-88)*

INSURANCE

ALL PRODUCTS CLAUSES

OMA supports legislation that prohibits health insurers from requiring physicians to participate in all-provider panels offered by the plan as a condition of participating in any one. *(I-98)*

The AMA should petition the U.S. Department of Justice to render an opinion on the antitrust implications of "all products" clauses, and OMA asks the Attorney General to review the legality of the anti-competitive aspects of "all products" clauses in Oregon contracts. OMA asks the Oregon Insurance Commissioner to determine whether the anti-competitive/pro-competitive aspects of "all products" clauses comply with the Unfair Trade Practices Act and the Patient Protection Act, and to what extent these clauses impact the conduct of Oregon-based insurance companies relative to consumer access and services in the current marketplace. *(I-98, Reaffirmed June-12)*

COMMUNICATION TO PATIENTS

OMA should discourage health insurance carriers from using inflammatory language or accusatory language on patient communications that are likely to cause damage to the physician/patient relationship or imply to the patient that the physician's integrity is in question. OMA should encourage civil and courteous communication between all parties, including insurers, physicians, physician assistants and staff members, in the interest of better patient care. *(I-01, Reaffirmed June-12)*

CUSTOMER SERVICE OF HEALTH INSURANCE COMPANIES TO PROVIDERS

The OMA advocates the Department of Consumer and Business Services to release de-identified complaint submissions to the public. And, the OMA's Policy Committee recommends policy that addresses customer service of payers with regard to physician-patient advocacy and evaluates each insurance company based on feedback obtained. *(Sept. 2018)*

MONOPOLY

OMA should lawfully oppose further acquisitions, mergers, or other collaborative arrangements between any health insurers in Oregon that, in the opinion of counsel, would create an unfair monopolistic competitive advantage. *(I-98, Revised June-12)*

PATIENT PROTECTION

OMA believes that patients should have the right to receive from their insurer the contract between the insurer and their physician. *(I-96, Reaffirmed A-11)*

STANDARIZED INSURANCE CARDS

The OMA recognizes the need for insurers to standardize insurance cards with effective dates, primary care provider, referral requirements, copay amounts, network, list of insured under subscriber, Group and ID numbers, and be made on printed material; and that a universal format also be applied in the same manner to explanation of benefits. (*October 2016)*

THIRD PARTY PAYOR AUDITS

OMA should develop contractual guidelines on the factors to be considered by individual physicians in order to arrive at a reasonable charge for physician and staff time devoted to compliance with third party audits and protocols. *(I-99)*

OMA should solicit periodically from the membership an appraisal of the validity, timeliness, and relevance to actual practice of managed care audits of individual physician performance and an accounting of due process review of the audit results by practicing physicians before publication to plan subscribers. *(I-99)*

OMA should ask the Oregon Insurance Commissioner to determine whether the major Oregon insurance company managed care organizations comply with the Patient Protection Act in providing periodic, comparative and accurate utilization data for all practicing physicians in the insurance plan. *(I-99)*

THIRD PARTY PAYOR EXPLANATION OF BENEFITS (EOB) STATEMENTS

OMA is in support of the standardization of third party payor explanations of benefits (EOBs) which are sent with payment for physicians' services so that such explanations conform in size, use of standardized codes, explanation of payment denials, layout of patient identification information, and further include payor name and phone, billed amount, allowed amount, deductibles, patient balance and paid amount. *(I-91, Revised June-12)*

PROTECTING PATIENTS FROM PREDATORY INSURER POLICY REGARDING EMERGENCY CARE

The OMA supports legislation precluding claim rejection after the fact for emergency care. *(June-18)*

MEDICAL EDUCATION & RESEARCH

RESEARCH

OMA strongly supports the humane use of animals in biomedical research in all educational institutions and research facilities; supports intensifying its activities to inform the general public about the need for the use of animals in research and respond to unfounded attacks against the proper and humane use of animals in biomedical research; supports and promotes legislation that is favorable to biomedical research at local, state and national levels, and continues to oppose restrictive legislation. *(I-90, Reaffirmed A-11)*

MEDICAL EDUCATION - CONTINUING

ACCREDITATION

Essentials for Accreditation of the Accreditation Council for Continuing Medical Education were adopted as OMA policy for use in its accreditation of intrastate providers of continuing medical education under the auspices of the Institutional Accreditation Committee. *(I-83, Reaffirmed A-11)*

OMA adopted as policy a procedure for appealing decisions of the Institutional Accreditation Committee by sponsors of continuing medical education seeking accreditation. *(A-92, Reaffirmed A-11)*

Revised Essentials for accreditation of the Accreditation Council for Continuing Medical Education were adopted as OMA policy for use in its accreditation of intrastate providers continuing medical education under the auspices of the Institutional Accreditation Committee. *(A-99, Reaffirmed A-11)*

CS II EXAMINATION

OMA advocates for our state medical board to eliminate the USMLE Step 2 CS and the COMLEX Level 2-PE as a requirement for LCME-accredited and COCA-accredited medical school graduates who have passed a school-administered, clinical skills examination; and for the appropriate state medical associations and medical licensure stakeholders to work on the creation of a mutually agreed-upon standardized clinical skills examination to be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and as a substitute prerequisite for future licensure exams. *(October 2016)*

ENHANCING HEALTHCARE DIVERSITY IN OREGON THROUGH K-12 MENTORSHIP INITIATIVES

The OMA supports funding for K-12 healthcare careers programs aimed at underserved communities with limited healthcare professionals production and retention. And the OMA will encourage Oregon's professional healthcare schools to partner with Oregon's K-12 schools to support healthcare career programs. (*February 2024*)

COMMERCIAL SUPPORT

OMA adopted as policy the "Standards for Commercial Support of Continuing Medical Education" developed by the Accreditation Council for Continuing Medical Education. *(I-92, Reaffirmed A-11)*

OMA adopts as policy the updated Accreditation Council for Continuing Medical Education Standards for Commercial Support. *(I-04)*

FELLOWSHIP (UNOFFICIAL)

OMA strongly suggested that the Oregon Health Sciences University consider opening a practical continuing medical education program that contains the following elements:

1. A voluntary system whereby a physician could attend as an "unofficial fellow" a training session of one or more weeks in their specialty area;

2. A system whereby that practitioner's practice during said training session would be assumed by a resident, fellow or other qualified physician from the medical school; and

3. That OHSU determine compensation to those in training, based on costs. *(A-97, Reaffirmed A-11)*

FUTURE DIRECTION IN CONTINUING EDUCATION

OMA policy statement on medical education was adopted in response to the December 1979 AMA report, "*Future Directions for Medical Education*." Addressing medical education as a continuous process which requires the ongoing scrutiny of all segments of the medical profession, OMA policy statement is as follows:

1. Cultural education of physicians. The education of physicians prior to entrance to medical school should encompass a broad cultural education in the liberal arts and social sciences in addition to the biologic, mathematical and physical sciences requisite, as a base for and understanding of, the medical sciences. Additionally, the admission selection process should encompass more than technical skills/knowledge assessments to include moral, ethical and behavioral characteristics.

2. Societal expectations and academic freedom. While realistically recognizing that medical schools cannot be self-sustaining, they should nonetheless remain as unencumbered as possible from the expectations and requirements of potential and actual benefactors and grantors.

3. Generalism and specialism in education. Institutions providing medical education should recognize the need for a comprehensive approach to the training of physicians, which would invite a broader exposure to the entire spectrum of clinical disciplines as well as exposure to the benefits of voluntary and part-time teaching physicians who practice medicine in community hospitals. To this end, OMA expresses concern regarding the decrease in influence and loss of stature of major clinical departments in some medical schools and hospitals resulting from specialism, yet recognizes the difficulty of reversing such a clearly established trend.

4. United States citizens seeking a medical education. While health care may be a right in the United States, it does not follow that every U.S. citizen who is qualified and has the means should ultimately expect to practice medicine in the United States. In fact, continuation of this policy will compromise the quality of the medical profession and ultimately the quality of the care it provides.

5. Evaluation of competence. The evaluation of each student's non-cognitive abilities (e.g., behavioral characteristics, interpersonal relationships) should be regarded as an essential part of the assessment process. Faculties of medical schools should conduct this evaluation as effectively and objectively as possible as part of their responsibility in granting the MD degree.

6. Licensure. OMA agrees that eligibility requirements for the issuance of a license should consist of evaluation instruments designed to assess an applicant's knowledge, problem solving ability and clinical judgment in the general field of medicine and should include documentation of an applicant's non-cognitive capabilities, and moral and ethical qualities.

7. Accreditation. OMA agrees, as part of its responsibility to the public and all segments of the medical profession, the AMA should continue to accept major responsibility in defining minimal standards for the evaluation of medical education at all levels, and should continue to participate in accreditation at all levels and make appropriate

recommendations and changes where the need for change is demonstrated. *(A-80, Revised A-11)*

GENDER-BASED VIOLENCE AND DISCRIMINATION IN HIGHER EDUCATION

The OMA adopts the following policy statement regarding Gender-Based Violence and Discrimination:

Gender-Based Violence and Discrimination in Higher Education

OMA recognizes that institutions of higher education are responsible for the climates and cultures they create, and OMA supports policy that promotes greater accountability regarding gender-based discrimination and/or violence in institutions of higher education in Oregon.

The OMA adopts the following recommendations regarding Gender-Based Violence and Discrimination in Higher Education:

Higher Education Reforms

Number 1: Public and private institutions of higher education in Oregon should adopt the following reforms in order to prevent instances of gender-based violence and discrimination and protect survivors during the reporting process.

- Clearly identify who is a designated reporter, who is an assisting employee, and who is a confidential employee, as modeled by the program currently in place at the University of Oregon.
- Constantly strive to prevent instances of gender-based discrimination and violence on their campus, making use of resources to include, but not limited to, those provided by the Oregon Attorney General's Sexual Assault Taskforce.

Higher Education Climate and Culture Surveys

Number 2: In alignment with legislative updates included in the 2022 Reauthorization of the Violence Against Women Act, public and private institutions of higher education in Oregon should administer climate surveys at an interval that best meets the needs of the institution, or at minimum every other year.

Number 3: Institutions of higher education in Oregon should administer culture surveys at an interval that best meets the needs of the institution, or at minimum every other year.

Number 4: Results of climate and culture surveys should be made available to the public, and institutions of higher education should publicize how they are acting on the results.

Number 5: Institutions of higher education should not be rewarded or penalized based on the results of climate and culture surveys, and that the results of the surveys not be admissible in a federal or state court proceeding unless the court, in its discretion, determines that the information is material to the underlying claim or defense.

Higher Education Support Services

Number 6: Public and private institutions of higher education in Oregon should provide survivors of gender-based discrimination and/or violence with support services, to include, but not be limited to, healthcare, mental health, and legal support.

- Support services should be actively promoted and made readily available online and elsewhere.
- Barriers to accessing support services should be removed, including but not limited to, cost, transportation, childcare, access, etc.

Number 7: In order to remove barriers to support services for survivors, public and private institutions of higher education in Oregon should:

- Form a bloc to apply for grant funding at the federal and state level.
- Use grant funding to directly pay for services on behalf of survivors.
- Decrease reliance on unreliable federal funding and instead fund programs for survivors themselves or secure funding at the state level.

(September 2022)

MEDICAL STUDENTS

The OMA supports state and federal policies that will decrease the financial burden on new physicians and PAs as follows:

1. Decrease tuition and overall medical and physician assistant student debt.
2. Decrease interest rates for educational loans.
3. Allow for diverse repayment options.
4. Eliminate the caps and limitations on educational loan interest deductibility.
5. Seek and support other options within the state to decrease the financial burden of medical students.
6. OMA shall convene a task force, which would report twice yearly to the Executive Committee, to address the issues listed in the comments section and bring those to the attention of those parties who can have an influence on student debt.

(April 2013)

OREGON HEALTH & SCIENCE UNIVERSITY

OMA supports the Oregon Health & Science University School of Medicine and urges its members to promote the School of Medicine to the citizens of Oregon, the Legislature, and the physicians in Oregon*. (I-77, Reaffirmed A-11)*

WESTERN UNIVERSITY OF HEALTH SCIENCES COMP-NW RECOGNITION

The OMA amends current policy to include Western University of Health Sciences COMP-NW; and the OMA urges its members to promote the Western University of Health Sciences COMP-NW to the citizens of Oregon, the Legislature, and the physicians of Oregon. (*June 2021*)

MEDICAL LIABILITY REFORM

The OMA will explore a voluntary Early Discussion and Resolution program that protects physicians' rights and addresses the cost and burden of medical liability. *(June-12)*

MEDICARE

BIPA

OMA supports the interpretation of the BIPA 2000 provision that drugs and biologicals which are not usually self-administered by the patient be covered by Medicare in a manner consistent with Congressional intent.

OMA advocates that CMS and its Medicare contractors only exclude a drug or biological from its coverage when there is evidence that the majority of the Medicare patients using that drug are personally self-administering it.

OMA supports the interpretation of the BIPA 2000 provision that Medicare coverage be based solely on the beneficiary's ability to self-administer drugs and not the ability of family members to administer the needed injection.

OMA asks the AMA to advocate that CMS address the failure of allocation of Part A funds to cover Part B services that have changes from inpatient to outpatient delivery. *(Re-affirmed I-04)*

CARRIERS

OMA requests development of reasonable minimal performance criteria for Center of Medicare & Medicaid Services (CMS) selection of Part B Medicare Intermediaries based not only on cost, but proven ability to provide payment of claims and customer service, and that OMA requests development of a Carrier Performance Scorecard based on these criteria. Furthermore, OMA demands that Center of Medicare & Medicaid Services (CMS) audit any Part B Medicare Intermediaries that fail to comply with such criteria. *(I-97, Reaffirmed A-11)*

NATIONAL REIMBURSEMENT LEVEL

OMA encourages our federal congressional delegation to join with congressional delegations from other Medicare disadvantaged states to secure parity and fairness in the distribution of Medicare dollars. *(A-04)*

OMA supports a single CMS payment area with reimbursement at a level that raises or at least retains, but in no case lowers, the reimbursement rates of any current payment area, and that furthermore, OMA work toward ensuring that Oregon Medicare reimbursement levels are raised to at least the national average. *(Re-affirmed I-04)*

RATIONAL MEDICARE PAYMENT SYSTEM

The OMA adopts the American Medical Association's 11 Principles for Characteristics of a Rational Medicare Payment System.

Characteristics of a Rational Medicare Payment System

- Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for Medicare and Medicaid Services (CMS).

Ensuring financial stability and predictability

- Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.
- Recognize fiscal responsibility. Payment models should invest in and recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
- Encourage collaboration, competition and patient choice rather than consolidation through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.

Promoting value-based care

- Reward the value of care provided to patients, rather than administrative activities–such as data entry–that may not be relevant to the service being provided or the patient receiving care.
- Encourage innovation, so practices and systems can be redesigned and continuously refined to provide high value care and include historically non-covered services that improve care for all or a specific subset of patients, as well as for higher risk and higher cost populations.
- Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings. Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
- Provide timely, actionable data. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs they control or direct.
- Recognize the value of clinical data registries as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.

Safeguarding access to high-quality care

- Advance health equity and reduce disparities. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities. Physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
- Support practices where they are by recognizing that high-value care is provided by both small practices and large systems, and in both rural and urban settings.

Additionally, any rational Medicare payment system should have a rational approach to the work value associated with physician work.

See Appendix Q

(Sept. 2022)

MENTAL HEALTH

BENEFIT COVERAGE

OMA endorses treatment of mentally ill patients as integral and essential to health care delivery, treatment that should be covered by health care benefits in the same manner as other illnesses, and continue to support and foster the recognition and cooperation of all concerned with the medical aspects of the care of patients with mental disorders. *(I-89, Reaffirmed A-11)*

COMMITMENT OF THE MENTALLY ILL

OMA will work with the Oregon Psychiatric Association to devise solutions for Oregon's problems regarding involuntary commitment for mental disease or disorder. *(I-85, Reaffirmed A-11)*

DISCRIMINATION BY THIRD PARTY PAYORS

OMA believes that Medicare and all other insurance programs should not discriminate by diagnosis against persons suffering from mental illness, and patients treated for mental disorders in any setting be subject to the same coinsurance requirements as applied to other Part B services (i.e., 20 %) under Medicare.

OMA should pursue legislation to repeal Section 1833(c) of the Social Security amendments of 1965, which limits Medicare payment for outpatient psychiatric services to 62.5% of approved charges. *(A-92, Reaffirmed A-11)*

SHORTAGE OF SERVICES

OMA should request that the Governor’s Mental Health Alignment Work Group strongly recommend that action be taken to address the critical shortage of acute and long term mental health care services in the state. *(A-00, Reaffirmed A-11)*

OREGON HEALTH PLAN - MEDICAID

OREGON HEALTH PLAN (OHP)

OMA supports the Oregon Health Plan that extends basic health benefits to all uninsured Oregonians whose income is below the federal poverty level. It is based on a system of prioritization of health services from the most important to the least important. Implementation of the program requires waivers from OMA. OMA is on record as supporting the Oregon Health Plan, CMS and the Health Services Commission; being actively involved in its formation, activities and efforts to obtain the necessary waivers. *(I-88, Revised A-11)*

OMA affirms its support for the implementation and adequate funding of the OHP. *(A-91, Reaffirmed A-11)*

OMA finds that state general funds are the appropriate source of funding for the OHP and urges the Legislative Assembly to appropriate adequate funds to support this important program for the benefit of a particularly vulnerable segment of Oregon's citizens. *(A-91, Reaffirmed A-11)*

OMA will advocate that the Oregon Health Plan philosophy of citizen and physician involvement in the development of national health care priorities. The AMA is urged to advocate this prioritization system as one answer to the dilemma of infinite demand for health services with finite resources. *(A-94, Reaffirmed A-11)*

OMA affirms its support for mental health parity in the Oregon Health Plan. *(I-94, Revised A-11)*

OMA should urge AMA to explore ways to fund long-term nursing home care for the elderly separate from the rest of the Medicaid program. *(I-95, Reaffirmed A-11)*

OMA should participate in all meaningful discussions and forums that would address its concerns regarding the Oregon Health Plan, correct reimbursement inequities, and consider alternative benefit levels to make basic coverage available to all Oregonians. *(A-00, Reaffirmed A-11)*

OMA encourages legislative action that provides the same professional liability protection afforded to physicians at Oregon Health & Science University and their clinics by expanding ORS 30.36-30.30 (Tort Claims Act) to include all Oregon licensed physicians who provide care for individuals enrolled in the Oregon Health Plan or other state aided patients. *(I-03)*

Providers should work with payers, IPAs and CCOs to encourage reasonable efforts to assure patients will be able to attend their appointments as scheduled. *(January 2014)*

OREGON MEDICAL BOARD (OMB)

CONFIDENTIAL PEER REVIEW PROCESS

It is the policy of OMA to support a confidential investigative process that protects citizens, patients, and physicians in order to encourage the identification of issues and concerns, and public disclosure of any and all actions adopted by the Board and will oppose any effort to weaken fundamental principles of effective and responsible peer review. OMA supports international collaboration to ensure patient safety throughout the world. *(A-05)*

PATIENT SAFETY

OMA should work with Oregon Health Authority, Department of Human Services, Oregon Medical Board, Oregon Patient Safety Commission, and others to promote a culture of patient safety with Oregon's health system. *(A-03, Revised October 2013)*

PHARMACEUTICALS

CANCER DRUGS

OMA will petition the AMA House of Delegates to seek implementation of an expedited approval process for drugs for fatal cancers, as well as work to increase the availability of promising cancer drugs for compassionate care. *(I-00, Reaffirmed A-11)*

COST OF PRESCRIPTION DRUGS

OMA encourages physicians to educate themselves about the relative cost and cost-effectiveness of drugs they prescribe and that OMA provide information about Rx Assist and other programs available to defray the cost of drugs to patients who simply cannot afford them. *(A-99, Reaffirmed A-11, Revised October 2013)*

DIRECT-TO-CONSUMER ADVERTISING

The OMA supports the Oregon Health Policy and Research's program in association with the "Attorney Generals' Consumer & Prescriber Education Grant" that educates physicians and patients to counter the influence of direct-to-consumer marketing strategies. *(I-99, Revised A-11)*

FORMULARY

OMA encourages Independent Practice Associations to use the Health Resources Commission evidenced-based reports to guide their formulary decisions.

OMA will inform members of the benefits of the Practitioner Managed Prescription Drug Plan (PMPDP) process, including a web link of OregonRx.org, articles in *STAT* and other publications, and by adding it to the OSPA/OMA Commercial Health Plans' Composite Formulary Guide for Oregon and SW Washington. *(I-02)*

GENERIC DRUGS

OMA endorses and promotes the prescribing of generic drugs when appropriate as they have been proven as effective, safe, use the same ingredients, have the same risk-benefit profile, have the same pharmacokinetics, and have the same manufacturing standards as brand name drugs. *(A-04)*

GIFTS FROM INDUSTRY

[See PROFESSIONAL STANDARDS]

POLYPHARMACY AND DEPRESCRIBING WORKGROUP RECOMMENDATIONS

1. That the OMA assemble a task force of physicians, physician assistants and others on the healthcare team including representatives from different specialties and other clinical experts to address the issue of medication overload. Possible functions of the task force could include:

   (a) Review, identify, assemble, and recommend existing resources for posting on the OMA website including evidence-based tools, algorithms, applications, and guidelines.

   (b) Consider deprescribing curriculum recommendations for the state's medical and physician assistant schools.

   (c) Review and promote CME that has already been developed by other organizations

   (d) Establish a liaison with the American Medical Directors Association (AMDA) for their Drive to Deprescribe Program, the American Geriatrics Society, the Canadian

Deprescribing Network and the U.S. Deprescribing Network, or other organizations working on polypharmacy and deprescribing.

2. That the OMA develop or co-sponsor Continuing Medical Education and other educational programming on recognizing and addressing polypharmacy and the concept and practice of deprescribing.

3. That the OMA collaborate with organizations including, but not limited to, medical societies, health care providers, payors and health plans, community organizations and other stakeholders, to explore how to best engage the public and mobilize public health efforts to address polypharmacy and deprescribing.

See Appendix P: APPENDIX P: POLYPHARMACY AND DEPRESCRIBING
(*Feb. 2022*)

PRESCRIPTION DRUG PRICE TRANSPARENCY

The OMA advocates for a policy that requires disclosure of information relating to the cost and pricing of prescription drugs, to provide accountability to the state and its citizens for prescription drug pricing. *(Feb.-18)*

PRESCRIBING GUIDELINES

[See PRESCRIBING GUIDELINES]

PROFESSIONAL LIABILITY INSURANCE

OMA is committed to the provision of malpractice loss prevention education programs and materials for its members to reduce professional liability losses and assure better medical care for patients. *(A-83, Reaffirmed A-11)*

OMA will pursue state legislation directed toward physician liability insurance relief by creating an insurance subsidy for Oregon physicians providing obstetrical care in rural areas, or other avenues of liability insurance relief. In addition, OMA will give priority to work on state and national efforts at tort reform, liability insurance evaluation and other avenues to address the national crisis in health care brought about by the premium increases and/or discontinuation of medical liability insurance programs.

OMA will vigorously pursue a variety of solutions through the legislative process:

1. A modified non-economic cap that allows a jury to override the cap upon finding of gross malpractice.

2. Periodic payment where future damages are awarded for economic and non-economic damages.

3. Amend existing collateral benefits statute to require the court to offset any damage award by the amount of any collateral benefits received.

4. Establish a sliding scale for attorney contingency fees, lowering the percentage, as the damage award grows higher.

5. Establish mandatory mediation of a medical malpractice claim upon the request of the defendant.

6. Expand discovery rules allowing for discovery of experts and limit discovery to identification of the parties' experts and the right of the opposing party to depose the expert.

7. Define "Informed Consent" in terms of the "Objective Patient Standard."

8. Limit interest on damage awards to the current rate of interest paid on U.S. Treasury Bills.

9. Prohibit a plaintiff from transferring a damage award into a trust on behalf of other family members during the plaintiff's lifetime.

10. Amend the Joint and Several Liability Statute (ORS 18.485) to provide:

    a. Several liabilities only.

    b. Allow a defendant to prove liability of another entity and reduce any damage award to the extent of the liability of the other party.

    c. Any prior damages provided to plaintiff pursuant to a settlement with another party shall be disclosed to the court and deducted from any damages awarded plaintiff. *(I-02)*

The OMA will be the resource of information on physician workforce issues including documentation of the condition of the medical liability insurance industry in Oregon (I-05)

OMA and all its component societies fully support and endorse the continued funding of the Oregon Rural Medical Liability Program and urge all members of the Oregon legislature to pass pending legislation without further delay. *(A-11)*

PROFESSIONAL CONSULTATION COMMITTEE

OMA members of the Professional Consultation/Professional Assessment Committee should be prohibited from indulging in any case review for the plaintiff's attorney that relates to professional liability other than for the Committee during their term on the Committee. *(A-75, Reaffirmed A-11)*

TORT REFORM

OMA reaffirms its support for enactment of meaningful, broad-based tort reform, and further encourages physicians to discuss the need for tort reform with their legislators, patients, employees, neighbors and others in their community. *(I-86, Reaffirmed A-11)*

OMA should seek legislation that would:

1. Waive the medical privilege upon the filing of a complaint for bodily and/or emotional injury, permit discovery by deposition of all treating physicians.

2. Mandate disclosure of experts prior to trial, requiring plaintiffs to disclose a) name, address and specialty of each expert, b) the CV of each expert, and c) opinions the expert intends to give and the facts and other factors upon which the opinions are based.

3. Require defense to provide the same information to the plaintiff within 20 days thereafter. *(I-92, Reaffirmed A-11)*

OMA should study alternative methods of settling malpractice disputes other than tort that are compatible with the Federal and Oregon Constitutions, or of modifying tort so it serves both the public and the profession more equitably than at present. *(A-01, Reaffirmed A-11)*

PROFESSIONAL STANDARDS

ATTORNEY-PHYSICIAN RELATIONSHIPS

OMA endorses the "Oregon Medical Association/Oregon State Bar Association Rules of Conduct Governing Attorney-Physician Relationships" and recognizes the document as official OMA policy. *(A-83, A-84, Reaffirmed A-11)*

Adopted at the annual House of Delegates, 1983.
Revised at the interim House of Delegates, 1984.
Reaffirmed at the annual House of Delegates, 2011.

BROKERAGE OF BODY PARTS

OMA opposes the selling or for-profit brokerage of non-regenerating body parts. *(I-83, Reaffirmed A-11)*

CAPITAL PUNISHMENT

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.

A physician may make a determination or certification of death as currently provided by law in any situation. *(I-84, Reaffirmed A-11)*

CONTRACTUAL ARRANGEMENTS – RESTRICTIVE COVENANTS

Contractual arrangements among physicians practicing together which, in the event of their separation, absolutely proscribe any of them from practicing within a certain geographic area for a certain period of time are not in the best interests of affected patients or the general public and are to be discouraged.

Contractual arrangements between a physician joining an established practice may, in the event of the former party's separation from the practice and establishment of a competitive practice, permit the latter party to collect from the former reimbursement for actual expenses incurred to recruit and subsidize that physician, provided allowance is made for amortization of such expenses during the physician's association with the practice.

In all contractual matters, physicians should seek appropriate legal and other advice to assure they clearly understand and agree to the terms of documents they sign. *(A-92, Reaffirmed A-11)*

CORPORATE PRACTICE OF MEDICINE

The OMA believes that clinical practices should not be absorbed by non-clinical businesses unless that business can demonstrate that its proposed ownership will protect the following principles:

Number 1: The patient-clinician relationship is paramount.

The patient-clinician relationship is at the heart of medicine. Medical decisions should be made by the patient and their treating clinicians. Patients should be free to choose their clinician. Clinicians should be free to practice medicine based on their training and knowledge, with the ability to report safety issues that affect patient care

Number 2: Preserve independence of clinical decision making.

Non-clinical ownership and management of medical practices could lead to manipulation of the delivery of health care services that is not in the best interests of patients or clinicians.

Patients should not have time with clinicians inappropriately restricted by the business interests of non-clinical owners.

Clinicians should not have restrictions on their ability to inform patients of the options they have to address their health care needs (i.e., no non-disclosure or non-disparagement policies that prevent communication with the patient or others).
Clinicians should not be required to promote or discourage treatment options based on non-clinical priorities.

When a business decision is contrary to a clinical decision and the decision directly impacts the delivery of care, the entity and its non-clinical decision-makers should be legally responsible for that business decision.

Number 3: Preserve patient access to health care.

Community access to healthcare should not be impaired by business entity conduct that is anti-competitive and needlessly restrictive. The widespread use of restrictive covenants in clinician employment agreements such as noncompete clauses should not be enforceable.

Number 4: Strive to elevate good patient care over profit motives.

There can be an inherent conflict of interest between providing good medical care and the need for a business entity to increase revenue and cut expenses in order to make a profit.

Business entities, whether profit or nonprofit, should not be able to benefit from generating unnecessary care nor from denying or delaying care.

Business practices and policies that are detrimental to the delivery of good medical care should be discouraged and those include but are not limited to: clinically inappropriate delaying of care;

prior authorization mandates; limiting access to clinicians through narrow or inadequate networks; insufficient staffing and compensation; and imposing non-medical policies that are contrary to evidence-based medicine.

Clinicians should be compensated fairly for all their work including both clinical work and non-clinical administrative work.

The fiduciary responsibility to act in the financial interests of a business entity and its owners should not conflict with the professional responsibility of clinicians to act in the medical interests of their patients.

Number 5: There needs to be an enforcement mechanism.

Business conduct in healthcare that leads to higher prices for care, reduced access to care, and lower quality of care is anti-competitive conduct. The Oregon Department of Justice Antitrust Division is an appropriate state agency to charge with investigating and prosecuting anti-competitive conduct here in Oregon. Clinicians who have evidence that business conduct in their workplace is detrimental to good patient care should have a safe and accessible avenue to report such evidence confidentially, without fear of reprisal, and with the expectation the agency will conduct an appropriate investigation. The agency should be empowered with the authority to impose civil monetary penalties, require corrective action, and for repeat offenders, seek other appropriate remedies to protect Oregonians. *(Oct. 2024)*

DISPENSING BY PHYSICIANS

It is OMA policy that the traditional checks and balances provided by a system authorizing physicians to prescribe and pharmacists to dispense are essential to the public health and welfare of the consumer. Individual physicians must make their own decisions on this issue based on applicable laws and the health needs of their patients. *(A-87, Reaffirmed A-11)*

DISRUPTIVE PHYSICIAN

OMA resolves to explore ways and means to prevent misuse of the “Disruptive Physician Doctrine,” and that the review of the subject include consideration of definition of terms, case finding, applicable law, the applicability of “whistle blower” statutes, the feasibility of requiring external fair hearings in the court system at the option of subject physician and requests for assistance and advice from the AMA. *(I-03)*

DUTY TO INFORM

The prescriber has the duty to inform patients of the effects of the prescribed drugs consistent with good medical practices and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication. Each professional organization has a responsibility to educate and inform the public on the proper handling and use of controlled substances. *(A-82, Reaffirmed A-11)*

ELECTRO-CONVULSIVE THERAPY

The administration of electro-convulsive therapy and psychotropic drugs are recognized modalities of medical treatment and should be subject to the same regulations and precautions for patient safety and welfare as any other medical and surgical procedure. OMA will strongly oppose any proposed state legislation that would restrict the practice of medicine beyond the recognized and traditional tests for safety and efficacy now required and practiced under current

Oregon laws pertaining to medical practice, by medical ethics and by review of physicians' peers. *(I-76, Reaffirmed A-11)*

GIFTS FROM INDUSTRY

It is OMA policy regarding relationships with the pharmaceutical industry that it should clarify the mode and motives of physicians' relationships with the pharmaceutical industry and other suppliers of medical equipment and devices.

OMA encourages this continued relationship, emphasizing the following goals:

- To maintain the highest possible standards in medical education pertaining to medicine and surgery and related disciplines.
- To promote the highest possible standards in clinical practice, education and research in all branches of medicine and surgery and related disciplines.
- To promote the highest standards of patient care and promote the public interest relating to medicine and surgery.
- To promote the highest standards in the allied health professions and services as they relate to medical and surgical practice.

OMA encourages the following types of support:

- Direct support for innovative pilot education projects for physicians and allied health professionals.
- Direct support for scientific programs at medical meetings.
- Direct support for patient educational projects.
- Direct support for clinical and research projects.
- Direct support for endowed chairs in all aspects of medical education.

OMA does not endorse any significant gift, financial or otherwise, by the pharmaceutical industry or other suppliers of medical devices to physicians, clinics, or other medical facilities.

The Oregon Medical Association re-emphasizes to its members that physicians should not receive compensation from pharmaceutical firms or suppliers of medical devices in return for prescribing or using their products. *(A-83, A-91, Reaffirmed A-11)*

> *Adopted at the annual House of Delegates, 1983.*
> *Adopted the AMA Council on Ethical and Judicial Affairs "Opinion on Gifts to Physicians from Industry" at the annual House of Delegates, 1991.*
> *Reaffirmed at the annual House of Delegates, 2011.*

OMA and AMA should more aggressively publicize professional standards pertaining to the acceptance of gifts or favors in exchange for participation in pharmaceutical and medical device product presentations. *(I-99, Reaffirmed A-11)*

OMA should publicize professional standards on the acceptance of gifts from the pharmaceutical industry via *STAT*. *(I-00, Reaffirmed A-11)*

OMA should develop and distribute a press release on OMA policy of acceptance of gifts from the pharmaceutical industry. *(I-00, Reaffirmed A-11)*

OMA should invite pharmaceutical companies to comply with OMA policy on acceptance of gifts, and regularly make available to physicians and the public an up-to-date list of those companies who do comply. (*I-00, Reaffirmed A-11)*

OMA encourages physicians to get their information regarding pharmaceuticals, supplements and devices from unbiased, evidence-based, and peer-reviewed literature. The OMA urges physicians to stop accepting any gifts from pharmaceutical companies, including both large items (trips, meals) and small items (pens, notepads) and everything in between. Physicians should carefully weigh the ethical implications prior to accepting drug samples from pharmaceutical companies. Given the inherent bias of pharmaceutical representatives who detail physicians, physicians should consider giving priority to other sources of information regarding the efficacy and safety of pharmaceuticals. *(A-06)*

HAIR ANALYSIS

OMA agrees that use of hair analysis tests in the diagnosis of dietary deficiencies is scientifically unfounded and should be discouraged as a customary medical practice in this state, until such time as well-documented clinical research has been thoroughly developed in support of a contrary position. Until conclusive scientific research has been developed to support a valid relationship between hair analysis tests and the diagnoses of dietary deficiencies, patients should not be charged for such tests*. (I-75, Reaffirmed A-11)*

IMPAIRED PHYSICIANS

OMA supports the Health Professional's Service Program (HPSP), a formal and comprehensive program to detect and aid the impaired physician. *(A-81, Revised A-11)*

PHYSICIAN AND PA SAFETY NET STUDY

OMA supports the study of a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. *(Oct.-17)*

INTERPRETER SERVICES

OMA supports a state fund or alternate funding mechanism to reimburse physician practices for unreimbursed interpreter services. *(October 2016)*

MEDICAL TESTIMONY

The OMA endorses efforts made to define the credentials of expert witnesses in malpractice cases. Specifically, the OMA supports the use of expert witnesses who are American Board of Medical Specialties (ABMS) Board certified in a relevant specialty area in which the expert testifies, hold an active license to practice, and take into consideration prevailing standards at

the time of the incident or event. Further, the OMA supports the use of expert witnesses who testify honestly, competently review all medical record information, and base their testimony on a scientific peer-accepted medical foundation. *(October 2015)*

PATIENT-PHYSICIAN COVENANT

OMA believes that medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimization of the physician's materialistic self-interest, externally, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, caregiver, helper and advocate for the sick and for the health of all.

By its tradition and very nature, medicine is a special kind of human activity — one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not and must never be commercial entrepreneurs, gate closers or agents to fiscal policy that runs counter to our trust. Any defection from the primacy of the patient's wellbeing places the patient at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state and local professional societies; our academic, research and hospital organization; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus, we honor our covenant of trust with patients. *(I-95, Reaffirmed A-11)*

PATIENT - PHYSICIAN RELATIONSHIP

OMA's ethical policy regarding the physician-patient relationship is:

OMA encourages members not to exploit the special physician-patient relationship in any manner whatsoever.

Consistent with this preamble and the ethical guidelines of the American Medical Association, it is not unethical for physicians to dispense diets, vitamins and other health care products provided there is no exploitation of the patient.

Consistent with this preamble and the ethical guidelines of the American Medical Association, physicians should not recommend such health products when they are influenced by a direct or indirect financial interest in the enterprise supplying such products.

Consistent with this preamble, physicians should not use their office, clinic or hospital for the purpose of selling products or services that are not a part of the administration of medical care.

Consistent with this preamble, physicians should not use the physician-patient relationship to influence patients to buy or sell products or services that will result in financial gain for physicians. *(I-82, Reaffirmed A-11)*

OMA should continue to remind its members that it is unethical to exploit the special patient-physician relationship in any manner whatsoever; and that it is inappropriate to receive compensation from recruitment of other medical professionals to sell medically related products or devices in any marketing scheme. *(I-98, Reaffirmed A-11)*

OMA should develop ethical guidelines that will discriminate between the legitimate provision of medically related goods and services in physicians' offices, and profit schemes in which physicians exploit the trust inherent in the patient-physician relationship. *(I-98, Reaffirmed A-11)*

PEER REVIEW

OMA supports locally controlled, physician-directed peer review. *(A-81, Reaffirmed A-11)*

OMA should continue a program, in cooperation with the Oregon Association of Hospitals & Health Systems (OAHHS) to provide peer review and credentialing services to hospitals and medical staffs in cases where local involvement in such activities is difficult or impossible. *(I-86, Revised A-11)*

PHYSICIAN OWNERSHIP

OMA policy on physician ownership of health care facilities is as follows:

A physician may own or have a financial interest in a for-profit hospital, nursing home or other health facility, such as a freestanding surgical center or emergency clinic. However, the physician has an ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.

Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial gain would be unethical.

If a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. *(A-83, Reaffirmed A-11)*

SELF-REFERRAL

OMA endorses the AMA Council on Ethical and Judicial Affairs' guidelines governing self-referral to physician-owned medical facilities were adopted:

1. Physician investment in health care facilities can provide important benefits for patient care. However, when physicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

2. Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

    a. Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

    b. There is no requirement that any physician investors make referrals to the entity or otherwise generate business as a condition for remaining an investor.

    c. The entity must not market or furnish its items or services to referring physician investors differently than to other investors.

    d. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

    e. The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.

    f. Investment contracts should not include "non-competition clauses" that prevent physicians from investing in other facilities.

    g. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that they will not be treated differently by the physician if they do not choose the physician-owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.

    h. The physician's ownership should be disclosed, when requested, to third party payors.

    i. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

3. With regard to physicians who invested in facilities under the Council's prior opinion, it is recommended that they reevaluate their activity in accordance with this report and comply with the guidelines in this report to the fullest extent possible. If compliance with the need and alternative investor criteria is not practical, it is essential that the identification of reasonably available alternative facilities be provided. *(A-92, Reaffirmed A-11)*

THE IMPORTANCE OF WORDS TO MAINTAINING OUR COVENANT WITH PATIENTS

The OMA will use the appropriate clinical and professional title in any policy, correspondence, and internal documents especially when referring to a physician or physician assistant, but also to include fellow healthcare professionals (for example but not limited to NPs, DNPs, PsyDs, PharmDs, ND, DC) who have dedicated their lives to clinical care. *(Feb. 2023)*

PRESCRIBING GUIDELINES

CONTROLLED SUBSTANCES – DEA GUIDELINES

OMA endorses the guidelines from the DEA for prescribing controlled substances. *(A-82, Revised A-11)* See Appendix A

PRESCRIPTION WRITING OF NON-CONTROLLED SUBSTANCES

The following guidelines for prescription writing are intended to go beyond the minimal requirements of the law. Tempered with good moral and ethical judgment, they are for the purpose of enhancing patient care.

- The written prescription order should be precise and distinctly legible to assure exact and effective communication between prescriber and dispenser.

- Although the prescriber must provide his/her DEA number, preprinting the number on prescription forms is to be discouraged as this facilitates forgeries.

- When indicating refills, write out the proper instructions in addition to marking the appropriate box, as this section can be altered easily.

- Try to make prescription orders alteration proof. When prescribing a controlled substance, write out the actual amount, e.g., "Twenty (20) only" in order to allay attempts at alterations.

- The practice of preprinting prescription blanks with a "check-off" for the amount of the order (e.g., __ 1-10; __ 10-20, etc.) is not encouraged.
- The use of prescription blanks with proprietary names preprinted is discouraged.

- Proper security procedures for the storage and handling of blank prescription order pads should be instituted and followed. A common method of diversion of pharmaceuticals to illicit use is through the theft and subsequent forgery of prescription pads. Prescribers should keep extra pads in a locked drawer and should never leave pads unattended in an examination room.

- Use a separate prescription blank for each controlled substance prescribed.

- Prescribe no greater quantity of a controlled substance than is needed until the next check-up.

- Each prescriber should have his/her own individual prescription blanks. Printing with multiple names is not encouraged.

- If institutional blanks are used, the prescriber should print his/her own name, address and DEA registration number on the blanks.

- Institutions should discourage the use of institutional blanks for prescribing controlled substances. The prescriber should use his/her own blanks for this purpose. *(Reaffirmed I-04)*

USE OF CONTROLLED SUBSTANCES FOR TREATMENT OF PAIN

OMA adopts the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain, developed by the Federation of State Medical Boards of the United States, Inc., as OMA policy statement on treatment of chronic pain. See Appendix B *(A-99, Reaffirmed A-11)*

PUBLIC HEALTH

ALLEVIATING DIAPER NEED FOR LOW-INCOME FAMILIES

OMA supports legislative actions and other policies to reduce diaper need for low-income Oregon families and to improve access to an adequate number of clean, appropriately-sized diapers for infants and toddlers statewide. (*June 2023*)

CLIMATE AND HEALTH WORKGROUP RECOMMENDATIONS

1. The OMA adopts the following policy statements adapted from the AMA Policy on Global Climate Change and Human Health with changes to update the evidence and to accommodate the addition of physician assistants and clinical teams.

   (a) Support the findings of the Intergovernmental Panel on Climate Change's sixth assessment report (released 8/9/2021) and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, marginalized communities, and those with fewest resources.

(b) Support educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, contributions to health care disparities and access to potable water supplies.

(c) Recognize the importance of physician and physician assistant involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognize that policymakers should work to reduce human contributions to such changes.

(d) Encourage physicians and physician assistants and their teams to assist in educating patients and the public on environmentally sustainable practices and the health risks associated with climate change and to serve as role models for promoting environmental sustainability.

(e) Encourage physicians, physician assistants and their teams and health systems to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently.

2. Support epidemiologic, translational, clinical, and basic science research necessary for evidence-based global climate change policy decisions related to the operation of health care facilities and institutions and in the delivery of health care. That the OMA encourage physicians and physician assistants and their teams to guide changes to their clinical practices and home health care institutions to reduce the climate impact of day-to-day operations.

3. That the OMA develop or co-sponsor Continuing Medical Education and other educational programming such as clinic or institution operations, public health mitigation and preparedness understanding individual medical risks and illnesses caused by climate change and the impacts on different communities.

4. That the OMA provide its members and their staff with available resources that have already been developed to reduce the climate impact of their clinical practice and institutions.

5. That the OMA work with other stakeholders including the American Medical Association and other physician organizations, and other organizations specializing in environmental solutions for health care practices.

6. That the OMA develop a plan to move the OMA toward carbon neutrality by 2030.

See Appendix O: APPENDIX O: CLIMATE AND HEALTH
(*Feb. 2022*)

CLIMATE CHANGE

OMA through the medical and public health community, supports acting promptly and decisively to address the serious public health threat of climate change by improving clinicians'

understanding of climate-health impacts and by fully engaging with the policy makers in support of appropriate efforts to stabilize the changing global climate and to mitigate its adverse medical and public health impacts. *(I-04, Revised A-11)*

DISASTER PREPAREDNESS AND RESPONSE

OMA will encourage our membership to become prepared personally and to prepare their office/business for all hazardous events (man-made or natural: biological, chemical, radiological, explosive, weather or earthquake). Additionally, we encourage them to participate in local community plans for such events and to attend exercises that test those plans.

OMA will encourage all members to find a role in a disaster response; that could be through their hospital, facility or employer, Community Emergency Response Team (CERT), religious (faith-based) team. Additionally, we strongly encourage those with no current role to consider the Medical Reserve Corps as an option.

Finally, the OMA supports training opportunities that enhance community disaster response. We will encourage and will work with the Oregon Health Authority to enhance these training opportunities such as Basic Disaster Life Support (BDLS) and Advance Disaster Life Support (ADLS) that provide skills-based learning. *(June-12)*

EMERGENCY RESPONSE PLAN

The OMA endorses participation in the Medical Reserve Corps and by extension, Oregon's SERV-OR registry as an important step in involving physicians in Oregon's emergency response plans. (*A-10)*

ENVIRONMENTAL HEALTH

The framework for policy planning and evaluation for the Community Health Committee and the OMA as it considers issues related to public and environmental health will be Healthy People 2020 from the US Dept. of Health and Human Services. Healthy People 2020 Topics and Objectives can be found at *www.healthypeople.gov/2020/default.aspx.*

The OMA and the CHC will draw upon this and other evidence-based quality review resources as indicated to determine appropriate policy for OMA's recommendation, including but not limited to:

- US Preventive Services Task Force (recommendations A and B)
- Advisory Committee on Immunization Policy
- Institute of Medicine
- Agency for Healthcare Research and Policy
- Other evidence-based quality review resources as indicated

As policy becomes governmental rule or regulation, it will be re-examined for potential deletion from the active Where We Stand document but archived in Where We Stood. Annual review of this section will keep it current. *(April-13)*

FIREARM RELATED INJURIES

OMA reaffirms its view that firearm-related violence represents a public health crisis which requires a comprehensive evidence based public health response and solution; and the OMA supports AMA efforts to lobby Congress to lift the research ban on firearm-related injuries and deaths. *(October 2016)*

GUNS

OMA recognizes that gun safety is a major factor in morbidity and mortality and, therefore, a public health priority.

OMA shall make known to its members the availability of gun safety educational brochures from a variety of credible sources for distribution to their patients.

The Oregon Medical Association shall introduce and support legislation making it an "A" misdemeanor to store or leave a loaded firearm within easy access of a minor (excepting minors who have passed a hunter safety course approved by the State Department of Fish and Wildlife, or other state-approved gun safety course).

All firearm dealers are required to provide purchasers with an educational pamphlet and a written warning about the law as well as post a sign describing the law prohibiting access to minors of a loaded firearm.

OMA supports legislation requiring that anyone selling a handgun at a gun show or flea market be required to do a criminal record background check on every buyer. *(I-98)*

OMA will introduce legislation requiring that all firearms sold in Oregon be equipped with trigger locks and accompanied by educational material describing proper gun storage, handling, and the risks associated with having a gun with children in the home. *(A-01)*

OMA supports legislation that in a case when a child brings a gun to school all firearms in the home of that child be impounded by law enforcement authorities (for a period of time to be determined by the courts) before the child is allowed to return to that home. *(A-01)*

OMA endorses and recognizes that the month of May is "Oregon Gun Safety Month." *(I-01)*

FIREARM RELATED INJURY PREVENTION LEGISLATION

The OMA shall set up a task force centered on firearm related injuries in the state of Oregon as a public safety hazard, focused on identifying the most impactful legislative strategies for further safeguarding the health of Oregonians as it pertains to these deaths and injuries. *(June-18)*

CESSATION OF SALE OF HIGH VELOCITY ("ASSAULT") WEAPONS

The OMA directs our AMA delegation to urge the AMA to take action to direct the US congress to pass legislation to ban the sale, transfer, manufacture, and importation of assault weapons and high capacity ammunition magazines to the to the American public. *(June-18)*

FIREARMS INJURY PREVENTION TASK FORCE

The OMA supports the Firearms Injury Prevention Task Force recommendations. See Appendix K *(June 2019)*

1. Firearm injury is a public health epidemic that affects all ages, races, and socioeconomic levels. The sequelae from firearm injury threatens the welfare and well-being of all Oregonians. Methods to reduce firearm-related injuries and deaths should be broad and comprehensive.

2. Gun ownership is valued by a substantial percentage of the population, including a portion of healthcare providers. Laws and policies to reduce firearm-related deaths and injuries should be evidence-based and consistent with the constitutional right of firearm ownership.

3. Deaths and injuries related to firearms are preventable. Firearm-related deaths and injuries can be reduced in Oregon.

4. Effective screening, assessment, counseling, and restricted access to firearms among high-risk individuals can preserve life and function.

5. Physicians and other healthcare providers have a responsibility to take action, lead public health efforts, and inform evidence-based legislation to reduce firearm injury and death.

6. Physicians and other healthcare providers must have unrestricted ability to discuss firearm safety, screen at-risk patients, and counsel patients and their families to avoid firearm injury.

7. Addressing key factors, including mental health crises, domestic violence, and alcohol misuse, are important aspects of reducing firearm injury.

8. Changing how violence is portrayed in society is a crucial step towards reducing firearm injury. The depiction of violence in the media, television, movies, and other aspects of society desensitizes the public and contributes to a culture of violence.

9. Expanded efforts in clinician training and public education about firearm injury are needed. These educational efforts should cut across all demographics and ages, representing all populations affected by firearm injury.

10. Research and research funding are needed to guide evidence-based methods to reduce firearm injury and deaths. Data collection, data sharing, and other efforts related to firearm research should be strongly supported across communities, agencies, and organizations.

SUPPORTING OREGON INITIATIVES FOR FIREARM HARM REDUCTION WHICH ALIGN WITH OMA EXISTING POLICY

The OMA supports the campaign to include the *Reduction in Gun Violence Act* and the *Reduction from Harm from Weapons Act* proposed by Lift Every Voice Oregon (LEVO) on the

Oregon State ballot for November 2022, through collaboration with LEVO and other stakeholders, and through education of our membership about the effort and how they can help. (*Feb. 2022*)

FLUORIDATION

OMA recognizes the health benefits of fluoridation and has long stood in support of fluoridating public water supplies. *(A-80, Reaffirmed A-11)*

OMA endorses legislative efforts of the Oregon Legislature to advance community water fluoridation as a safe and effective public health strategy to prevent dental caries and encourages statewide adoption to increase the Oregon population served by community water systems with optimally fluoridated water. OMA encourages physicians and physician assistants to become involved in the fluoridation issue by educating patients, citizens and civic leaders so that existing programs will continue and fluoridation will be undertaken where the drinking water fluoride is suboptimal. (*January-17*)

HARMFUL CHEMICALS IN CONSUMER PRODUCTS

The OMA supports state and federal legislation and administrative efforts to protect the public, particularly children, from harmful chemicals in consumer products by reducing the burden of toxic exposure. (*A-08)*

ENCOURAGING THE ADOPTION OF A SARS-COV2 ELECTRONIC DOCUMENTATION PROGRAM

The OMA encourages the Oregon Health Authority to adopt a program for portable electronic documentation of SARS-COV2 vaccination status. (*Feb. 2022*)

HEALTHCARE RIGHTS AND HUMANE TREATMENT OF INCARCERATED PERSONS

The OMA support and advocate for providing appropriate high quality medical care including treatment for mental health and substance use disorders to those who are incarcerated in local, state and federal correctional institutions in Oregon, including detention centers for undocumented people such as ICE detainment facilities.

In light of the current and future potential public health emergencies (particularly those related to communicable diseases) that OMA work in collaboration with AMA and other stakeholders to advocate for changes to incarceration and detention practices to include, but not limited to:

1) The safe cohorting of incarcerated persons to limit the disproportionately high spread of SARS-CoV2 or other communicable diseases within these populations and among those who work with them.
2) Selected decarceration of individuals not thought to be a risk to their communities in order to reduce the density of facility populations during outbreaks of communicable diseases.
3) The limitation or elimination of using punitive solitary confinement as medical isolation for persons infected with SARS-CoV2 or other infectious organisms.

The OMA, in collaboration with AMA and other stakeholders, advocate for changes to incarceration and detention practices to address human rights issues which impact the health of inmates, those who work with them, and the families and communities they return to, including but not limited to:

1) Expanding access to substance use disorder and mental health treatment during incarceration and continuity of that care upon release
2) Limiting or eliminating the use of solitary confinement
3) Eliminating coercive or forcible sterilization practices
4) Consistent needs assessment on entry into correctional institutions and provision of age appropriate physical and mental health care for incarcerated or detained juveniles
5) Prohibiting cohorting of children in immigration detention away from their family unit. (February 2021)

INFORMING FUTURE PUBLIC HEALTH PANDEMIC EFFORTS: URGING A CONGRESSIONALLY-MANDATED COVID-19 COMMISSION

The OMA supports creation of and passage of federal legislation to create a congressionally-mandated non-partisan commission of legislators, and healthcare and public health experts which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness.

The OMA brings forth a resolution requesting that our AMA advocate for passage of federal legislation to create a congressionally-mandated non-partisan commission of legislators, and healthcare and public health experts which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness. *(Sept. 2020)*

NUCLEAR WAR/WEAPONS

It is OMA policy with regard to nuclear weapons that since the first nuclear weapons exploded fifty years ago, humanity has had to face the threat of mass destruction. Even a single nuclear bomb exploding in one city – whether through accident, terrorism or war – could kill hundreds of thousands of civilians. There is no effective medical response to a nuclear explosion – the only effective approach is prevention.

Even if all existing arms control treaties are fully implemented, 20,000 warheads still remain in the world – the equivalent of 200,000 Hiroshima bombs. The global destruction from their combined blast, burn radiation, and environmental effects would be so great that all human civilization could be destroyed.

We cannot accept that the danger of these weapons of mass destruction persists. Furthermore, as long as some countries possess nuclear weapons, others will inevitably seek to acquire them.

We call on the nations of the world, and especially on the nuclear weapons states, to enter immediately into negotiations to abolish nuclear weapons. *(I-98, Revised June-12)*

OMA supports the Policy Statement of the American Public Health Association, that:

1. Calls on the United States government to explicitly reaffirm its historical commitment to international treaties aimed at curbing the development and proliferation of nuclear weapons and weapons of mass destruction; and

2. Calls on the United States government to abandon plans to “modernize” its nuclear weapons arsenal and to abandon its plans to initiate a new era of nuclear testing; and

OMA also supports calling on the United States government to expedite the allocation of significantly increased resources to secure current nuclear arsenals in Russia and elsewhere, to prevent their falling into the hands of terrorists; and

OMA shows its support through communicating these messages to the AMA, the Oregon Congressional delegation, the medical community and the general public. *(I-04)*

OBESITY

OMA to take a coordinated multidisciplinary approach to address the obesity epidemic among adults and children in Oregon by:

a. educating physicians and the public about prevention and management of overweight and obesity;

b. recognizing that overweight and obesity are both personal and community responsibilities;

c. supporting evidence-based programs for clinical prevention of obesity because of its significant relationship with diabetes, high lood pressure and other chronic diseases;

d. urging physicians and patients to maintain a desired weight;

e. supporting social marketing efforts and media outreach directed toward promoting healthful food choices and increased physical activity;

f. collaborating with county medical and specialty societies, and other public and private organizations to promote daily physical activity and healthy, balanced eating by all Oregonians;

g. supporting policies and legislation that promote daily physical activity and healthy eating in Oregon; and

h. convening a task force consisting of members of the Community Health Committee and medical directors of public and private third party payors to work on the issues of coverage and reimbursement for childhood and adult obesity prevention and treatment. *(A-04)*

TREATMENT OF OVERWEIGHT AND OBESITY

OMA will work with the Oregon Health Authority to approach the Centers for Medicare and Medicaid to allow the state to amend its 1115 Waiver to allow coverage for the evidence-based, prevention and treatment of obesity; will work to introduce legislation in the state of Oregon to ensure commercial insurance coverage for evidence-based, prevention and treatment of obesity

for Oregon's citizens; and will introduce a resolution to the American Medical Association House of Delegates asking the AMA to join in efforts to convince Congress to address the affordability and accessibility of evidence-based, prevention and treatment of obesity across the United States. (*June 2023*)

ORAL HEALTH

The OMA delegation to the AMA supports efforts to increase awareness about oral health and access to oral health services. *(October 2016).*

PERMANENT SUPPORTIVE HOUSING

The OMA recognizes that a safe, permanent, and affordable home is needed for individuals to appropriately address medical needs, mental health concerns, or substance addiction. The OMA will work with stakeholders to support state policies, legislation, and investments that promote the development of affordable housing that incorporates supportive health services to help Oregonians who experience housing instability and high medical needs to achieve optimal health outcomes. *(Sept. 2018)*

SUPPORT FOR TENANTS RIGHTS: RENT FORBEARANCE DURING HOSPITALIZATION

The OMA supports efforts to provide legislative protections for renters who are hospitalized, from housing associated penalties for late rent payment such as late fees and negative credit reporting. *(October 2025) See Appendix AC*

HEALTHCARE DELIVERY AND ADVOCACY FOR PERSONS EXPERIENCING HOMELESSNESS OR HOUSELESSNESS

The OMA suppoorts the following policy statements on healthcare delivery and advocacy for persons experiencing homelessness or houselessness:

Principle 1: Access to high-quality healthcare, independent of housing status or stability, is a fundamental element of a just society in accordance with the OMA's commitment to providing universal health care.

Recommendation:

1. Acknowledge that Persons Experiencing Homelessness or Houselessness (PEH) represent a unique community in our state with unique needs. While a diverse community, PEH share commonalities and deserve consistent access to care with a focus on the amelioration of barriers to care.

2. Advocate for the highest quality of evidence-based, patient-centered care for PEH both within traditional healthcare settings and through the work of outreach teams.

3. Affirm that access to healthcare should not be conditional or dependent on housing stability, substance use, or mental health stability.

4. Encourage the delivery of healthcare services despite perceived or actual non-adherence, with attention to maintaining the safety of other patients, staff and clinicians.

5. Advocate for collaboration between healthcare organizations and organizations that work directly with PEH.

6. Advocate for financial reimbursement for street and shelter-based services among all third-party payers.

Principle 2: The OMA recognizes that social determinants of health negatively and disproportionately impact the health of those living on the streets. Innovative approaches to healthcare delivery and harm reduction may be necessary for the provision of equitable healthcare.

Recommendation:

1. Recognize that a Housing First model, where access to permanent housing is not contingent on mandatory therapy or substance use cessation, is an effective, evidence-based approach to improving the lives of PEH. While housing first is ideal, recognize that care can and should be delivered prior to housing stability.

2. Advocate for laws and policies that advocate for the creation of affordable, permanent housing, especially units with integrated social services systems and healthcare resources.

3. Advocate for laws and policies that protect the rights of PEH.

4. Oppose forced relocation (“sweeps”), a dehumanizing process that can lead to the criminalization of non-criminal activities and worsen health outcomes. Advocate for evidence-based approaches.

5. Promote the establishment, funding, and review of team-based mobile medical and social-service outreach practices.

6. Encourage the development of discharge plans for PEH that are holistic, cost-effective, evidenced-based, and take into account individual barriers to care.

7. Advocate for municipal interdisciplinary collaboration and coordination of care for PEH.

8. Promote the establishment of medical homes for PEH.

Principle 3: The OMA acknowledges that patterns of disease in the homeless or houseless community differ from those in the housed community. Specialized training and educational opportunities should be available for all learners and clinicians.

Recommendation:

1. Endorse the development of healthcare training curricula - focused on the pillars of trauma-informed care, harm reduction, and value-based care - within professional schools, graduate medical education programs, and continuing medical education. In addition to these pillars, curricula should address disease patterns, treatment responses, and barriers to care specific to PEH.

2. Encourage student involvement in programs that promote direct engagement and relationship-building with PEH.

3. Advocate for the funding of research in the care of PEH.

4. Recognize that improving the practice of medicine for PEH requires structured ongoing input from patients and communities. Advocate for the creation of patient advisory boards, lived-experience consultants, and community feedback sessions within healthcare institutions and medical education programs.

Principle 4: The OMA acknowledges that all patients have a right to self-determination in medical or health-related decision-making, and that while patients may not always make the best choices for their health, their choices are their own. Providing care for PEH requires a harm reduction lens.

Recommendation:

1. Recommend that healthcare organizations ensure that providers have access to training and continuing education in harm reduction principles to improve the quality of care provided to PEH.

2. Encourage the integration of harm reduction services—including needle exchange programs, supervised consumption sites, and medication-assisted treatment—into healthcare settings, ensuring they are accessible to PEH without stigma or barriers.

3. Acknowledge that working in this community can present unique challenges that are not typically encountered in standard practices. Peers and patients with lived experience as well as colleagues with expertise in working with PEH can better inform our practice

Principle 5: The OMA recognizes that PEH with terminal or long-term debilitating medical conditions experience excessive suffering.

Recommendation:

1. Advocate for legislation and funding initiatives directed towards increasing the number of medical respite beds.

2. Advocate for funding for medical respite programs that extend beyond short-term stabilization, ensuring continuity of care for patients with complex, long-term medical needs.

3. Advocate for equitable access to palliative care and hospice for all Oregonians, regardless of housing status.

4. Ensure that healthcare facilities and services comply with ADA guidelines as PEH are especially impacted by disability.

Principle 6: The OMA recognizes that providing quality care for PEH requires not only helping patients navigate social services and other barriers to health, but also confronting the profound emotional and psychological toll of witnessing exaggerated suffering. This work can be inherently stressful, leading to clinician burnout and frustration.

Recommendation:

1. Emphasize that all members of the healthcare team deserve support. Encourage the integration of trauma-informed mental health resources, peer support groups, and debriefing sessions into workplaces to help providers process grief, burnout, and moral distress associated with caring for PEH.

2. Promote education about healthcare for PEH to aid clinicians in understanding the complex behavioral issues that are inherent in this work, thereby improving preparedness for the job and minimizing burnout.

3. Recognize that healthcare organizations should take a leadership role in curating updated, dynamic guides to community resources and ensuring provider access to that information.
   See Appendix AA
   (*May 2025*)

POST-ACUTE, LONG-TERM CARE AND RESIDENTIAL FACILITY OPERATION IN HEALTHCARE EMERGENCIES

The OMA, in collaboration with other stakeholders, reviews the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities to better understand the emergency needs of LTC facilities (including managing gaps in staffing and resources) when responding to natural disasters and public health emergencies.

The OMA collaborates with other stakeholders in using this evidence to develop policy and guidance for state and local public health authorities to ensure safe operation of post-acute care services and long-term care and residential facilities during public health emergencies and natural disasters.

The OMA's AMA delegation bring forth a resolution requesting that AMA review the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters, with policy recommendations to include but not be limited to:

a. Planning for adequate funding and access to resources
b. Planning for emergency staffing of health care and maintenance personnel
c. Planning for ensuring safe working conditions of LTC staff
d. Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis.
   (February 2021; referred to the AMA June 2021)

PROMOTING AND ENSURING SAFE, HIGH QUALITY, AND AFFORDABLE ELDER AND DISABLED CARE THROUGH EXAMINING AND ADVOCATING FOR BETTER REGULATION OF AND ALTERNATIVES TO THE CURRENT, GROWING FOR-PROFIT LONG TERM CARE OPTIONS

The OMA advocates for business models in long term care for the elderly and disabled which incentivize and promote the ethical use of resources to maximize care quality, staff and resident

safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.

The OMA, in collaboration with other stakeholders, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.

The OMA's AMA Delegation * introduces a resolution to the AMA House of Delegates asking them to support these policies.
* Language of resolve was corrected to refer to the OMA's AMA Delegation
(*Feb. 2022*)

PROMOTION OF HEALTHY LIFESTYLES

OMA urges the promotion of healthy lifestyles as a core of preventive programs offered by physicians, health departments, health plans, and voluntary health associations and encouraged physicians to take advantage of "teachable moments" that arise when counseling pregnant patients. In addition to supporting non-smoking clinics, OMA physicians are asked to become exemplars for their patients and their communities by stopping smoking themselves. *(A-80)*

PUBLIC SANITATION

OMA affirms its long-standing policies in support of and advocacy for basic standards of public sanitation, including the provision of clean and safe public sources of drinking water to the people of Oregon and encourages its members to be active in supporting such efforts at the local, state and national level. *(A-99, Reaffirmed A-11)*

TOXIC CHEMICALS

Oregon Medical Association urges the AMA to support restructuring of the Toxic Substances Control Act to:

(1) require chemical producers to provide comprehensive chemical hazard information in forms that are appropriate for use by the public, workers, industry, and government; and

(2) serve as a vehicle to help federal and state agencies to efficiently assess the human and environmental hazards of chemicals in commercial use and reduce the use of those of greatest concern; and

(3) introduce complementary federal mechanisms to motivate investment, education, and research in safer ('green') chemical technology. *(A-08)*

SEAT BELTS

OMA recommends that all school buses and other school vehicles in the state be equipped with seat belts. It further urged that seat belt education be strongly emphasized in public school health education curricula and voted to transmit these recommendations to the State Superintendent of Schools and the Director of Pupil Transportation. *(A-85, Reaffirmed A-11)*

SPORTS MEDICINE

1) Traumatic Brain Injuries: "Minimal" through Concussion (a Spectrum)

a. We should be aware of guidelines for head/spinal injury prevention.
b. We should be aware of the guidelines for diagnosis and management of brain injury and especially immediate and sub-acute care of concussion.
c. This OMA policy covers all athletes of any age.
d. Links and point of service decision support tools e.g. smart phones will be posted on the OMA's public web page.

2) Heat-Related Injuries - The OMA believes that as parents, grandparents, guardians, medical care providers, team coaches/personnel and spectators, physicians, physician assistants, other health care providers and alliance section members should be aware of the guidelines from the Oregon School Athletics Association for the prevention, diagnosis and management of heat/weather-related injuries in sports and other outdoor activities for all athletes of any age. *(April-13)*

SUGAR SWEETENED BEVERAGES POLICY

The OMA, in alignment with the joint policy statement of the American Academy of Pediatrics and the American Heart Association endorsing an SSB tax, the Oregon Medical Association through collaboration with other similarly aligned organizations will seek to improve public health by jointly exploring options to reduce consumption of sugar sweetened beverages including education and possible taxes. (February 2020)

SKIN CANCER PREVENTION IN OREGON

The OMA reinforces and advances its stance on skin cancer prevention such that the OMA endorses the ban of tanning bed use in all individuals under the age of 18 in Oregon, additionally requiring tanning facilities to register with the state and undergo regular inspection by the Oregon Radiation Protection Services Tanning Program as detailed by the current law. The OMA also supports the use of sun protective clothing and the application and use of nonprescription sunscreen by students in Oregon while outdoors. Finally, the OMA strongly recommends Oregon's K-8th grade students receive skin cancer prevention education as part of physical education or equivalent class time, utilizing any of the free, widely accessible online curricula. *(June-18)*

SUPPORT FOR THE ESTABLISHMENT OF MEDICAL-LEGAL PARTNERSHIPS

The Oregon Medical Association encourages the establishment of medical-legal partnerships to advance health equity and better address the social determinants of health for patients across Oregon. *(June 2024)*

SYSTEMIC RACISM

1. **The OMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and as a barrier to appropriate medical care.** Racism is part of American society and therefore part of American health care. Health care professionals have the ability and obligation to recognize and untangle the influence of racism and discrimination in medicine.

2. The OMA **transforms the Equity Task Force into a standing Justice, Equity, Diversity, and Inclusion (JEDI) Committee** to address justice, equity, diversity, and

inclusion in our practice, institutions, and industry. OMA will ensure that the committee has a diverse membership and is of sufficient size to perform the anticipated functions. The committee will immediately develop a charter covering membership, function, and scope (which is to extend beyond issues of race, to include, but not limited to, those involving gender, sexual identity, ethnicity, religion, immigrant status and experience, language, disability, old age, poverty, and rural location). The committee will address tasks in these areas which they deem appropriate, but including:

a. Educating OMA members on the **influence of institutional and individual racism** and other inequities on the practice of medicine.
b. Advocating for policy changes that **improve equity in the health care professions and practice of medicine** in Oregon. This includes recruitment and retention of future physicians, physician assistants (PAs), and other healthcare workers from racially diverse communities and other underrepresented identities.
c. Recommending methods to reduce the **impact of racism on public health** and health outcomes. This includes recognizing, addressing, and reversing racially differentiated **health outcomes** for our patients.
d. Recognizing and addressing the major public health issue of violence against individuals because of personal characteristics. This includes identifying and supporting policies that **reduce violent injuries and death** among Black Americans and other people of color. In addition, especially during mental health crises, OMA will identify and support policies that **improve police interactions** with the community.
e. Promoting recognition of the inequalities in upstream **social determinants** (e.g., family wealth, housing stability, food security, employment, education) and their influence on the health and outcomes of our patients, in order to begin addressing these as public health issues.
f. **Expanding advocacy** to support policies that address these upstream social determinants.

3. The OMA **collaborate with other organizations** to promote health equity, inclusion, and diversity. Examples of possible collaborations could include supporting the formation of an Oregon chapter of the **National Medical Association (NMA)**, work on equity policies and solutions with other **physician and PA organizations**, and continuation of OMA engagement with the **Oregon Health Authority, Oregon Health Leadership Council and other organizations** in efforts to promote medical outcomes and improve social determinants of health. See Appendix N. *(June 2021)*

TOBACCO USE

1) Importance of issue: The primary public health goal of the OMA is to reduce illness, disability, and deaths related to tobacco use and second hand smoke exposure. Tobacco use is the single most preventable cause of disease and death in the US.

2) Basis of policy: Physicians, physician`s assistants and other health care providers can be effective in smoking cessation efforts.

   The US Preventive Services Task Force (USPSTF), part of the Agency for Research and Quality (ARHQ): found good evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and

pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after 1 year.

The USPSTF found good evidence that extended or augmented smoking cessation counseling (5-15 minutes) using messages and self-help materials tailored for pregnant smokers, compared with brief generic counseling interventions alone, substantially increases abstinence rates during pregnancy, and leads to increased birth weights. Although relapse rates are high in the post-partum period, the USPSTF concluded that reducing smoking during pregnancy is likely to have substantial health benefits for both the baby and the expectant mother.

The USPSTF concluded, and reaffirmed in 2009, that the benefits of smoking cessation counseling outweigh any potential harms: *www.uspreventiveservicestaskforce.org/3rduspstf/tobacccoun/tobcounrs.htm#clinical* .

3) The OMA vigorously endorses the 20 objectives related to Tobacco Use contained in Healthy People 2020: *www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=41*.

These objectives apply to all nicotine materials and delivery systems, excluding those regulated by the FDA as nicotine replacement, sensation or treatment products.

TU-1 Reduce tobacco use by adults
TU-2 Reduce tobacco use by adolescents
TU-3 Reduce the initiation of tobacco use among children, adolescents, and young adults
TU-4 Increase smoking cessation attempts by adult smokers
TU-5 Increase recent smoking cessation success by adult smokers
TU-6 Increase smoking cessation during pregnancy
TU-7 Increase smoking cessation attempts by adolescent smokers
TU-8 Increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in States and the District of Columbia
TU-9 Increase tobacco screening in health care settings
TU-10 Increase tobacco cessation counseling in health care settings
TU-11 Reduce the proportion of nonsmokers exposed to secondhand smoke
TU-12 Increase the proportion of persons covered by indoor worksite policies that prohibit smoking (*Note: this is already law in Oregon)*
TU-13 Establish laws in States, District of Columbia, Territories, and Tribes on smoke-free indoor air that prohibit smoking in public places and worksites (*Oregon law already covers tobacco smoke)*
TU-14 Increase the proportion of smoke-free homes
TU-15 Increase tobacco-free environments in schools, including all school facilities, property, vehicles, and school events
TU-16 Eliminate State laws that preempt stronger local tobacco control laws
TU-17 Increase the Federal and State tax on tobacco products
TU-18 Reduce the proportion of adolescents and young adults grades 6 through 12 who are exposed to tobacco advertising and promotion
TU-19 Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors

TU-20 (Developmental) Increase the number of States and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs.

4. Nicotine products and nicotine delivery systems should be consistently regulated. This specifically prohibits sale to, possession by and access by minors. *(April-13, Revised October-14)*

TOBACCO – MINIMUM AGE FOR PURCHASING TOBACCO PRODUCTS

The OMA advances their stance on tobacco use by endorsing a position in which the minimum age to legally purchase and consume tobacco products in the State of Oregon is raised to 21 years old. *(October 2016)*

PREVENTION OF YOUTH TOBACCO CONSUMPTION BY PROHIBITING FLAVORED E-CIGARETTES

The OMA reinforces and advances its stance on the prevention of youth tobacco usage by endorsing the ban of all characterizing flavors of e-cigarettes, including menthol, in the State of Oregon. *(June-18)*

SEXUAL VIOLENCE, INTIMATE PARTNER VIOLENCE AND HEALTHCARE - SUPPORTING SURVIVORS

The OMA endorses the CDC definitions of Sexual Violence and Intimate Partner Violence. The OMA affirms its support for survivors of Sexual Violence and Intimate Partner Violence and the provision of prompt, patient-centered, trauma-informed, and sensitive healthcare to all Sexual Violence and Intimate Partner Violence survivors. And, the OMA affirms its support of efforts to implement standardized, evidence-based education on the problem of Sexual Violence and Intimate Partner Violence and best practices for appropriately treating patients who are survivors of Sexual Violence and/or Intimate Partner Violence at all levels of physician and physician assistant education, training and practice. (*June 2019)*

VACCINES

The OMA recognizes the role of vaccines in protecting the health of individuals and communities. Therefore, the OMA supports efforts to ensure all individuals are fully immunized and the removal of the child nonmedical exemption process from Oregon law. OMA supports the vaccine schedule and recommendations established by the CDC. OMA members shall educate patients and families on the safety, risks, and benefits of vaccination and lead by example through vaccinating themselves and their families. OMA shall support both national and state scientifically-based policies that promote the safety of vaccinations and effectively serve to increase the number of individuals vaccinated against communicable diseases. *(Sept. 2020)*

SEXUAL AND REPRODUCTIVE HEALTH CARE

WOMEN'S HEALTH CARE

OMA shall continue to support public health and women's health initiatives, especially policies promoting breastfeeding, postpartum mental health, and equal access to care regardless of socioeconomic status. (June-17)

ABORTION POLICY, REVISED

That the OMA adopt the following revised and updated statement on abortion:

The OMA believes the decision to perform an abortion is best left to a patient and their clinician and will oppose legislation that restricts access to medical care, interferes with the confidential clinician-patient relationship, or criminalizes any evidence-based healthcare services and all proposals that link liability, loss of licensure, or economic sanctions to provision of legitimate medical services. The OMA opposes any legislation that would ban abortions based on gestational age or other factors. The OMA opposes the criminalization of self-managed abortion and will advocate against any legislation that seeks to penalize patients seeking abortions or persons assisting a patient in seeking abortion. The OMA urges Congress and the federal executive branch to take action to protect abortion access in all states.

It is recognized that clinicians may have moral judgments regarding abortion, but these moral judgments should not be imposed on the patient. A clinician who is consulted regarding termination of a pregnancy should supply the patient with information regarding abortions. If they are unwilling or unable to provide care for termination of pregnancy, they should direct the patient to a clinician who can provide that care. The specific type of procedure, personnel, technique, and location of abortion facilities should be consistent with up-to date evidence-based medical practice.

Medication abortion is a safe option for termination of non-ectopic pregnancies. OMA opposes any legislation that limits access to medication abortions, including restrictions on telemedicine use. Any FDA regulations of the prescription of mifepristone or misoprostol, the two most common medications which induce abortions, should be based on objective evaluation of risk to patient and consistent with other drugs with similar safety profile. The OMA urges the FDA to lift the Risk Evaluation and Mitigation Strategy on mifepristone. In addition, the OMA supports telehealth as a safe option for medication abortions and opposes any legislation that would limit or delay access to telehealth for abortion care.

Targeted Regulation of Abortion Providers (TRAP) laws are designed to limit access to abortion care by putting undue burdens on physicians and other clinicians who provide abortions and have been shown to worsen health outcomes. The OMA opposes legislation that puts burdens on clinicians performing abortions that are not applied to clinicians providing other medical services.

Federal reimbursement for abortion services under Medicaid and other state or federal matching fund programs should be determined on the same basis as any other medical procedure. The OMA opposes efforts to economically limit access to abortion in the state of Oregon.

That the OMA adopt the following statement on Crisis Pregnancy Centers:

OMA respects that there are a range of options for management of pregnancy including both adoption and abortion, however OMA opposes any use of state or federal funding for

nonmedical “Crisis Pregnancy Centers” or “Pregnancy Resource Centers” in which counselors without medical training or licensure offer non-evidenced based information regarding pregnancy options and management. Pregnancy options counseling is a conversation best had between a patient and their licensed clinician.
(September 2022)

BAN THE SHACKLING OF INCARCERATED PREGNANT WOMEN

The OMA supports a ban on the shackling of pregnant women in the third trimester and during labor, delivery and the immediate postpartum period. *(September 2020)*

BIRTH CONTROL / EMERGENCY CONTRACEPTION

OMA strongly supports the FDA’s emergency contraceptive drug Plan B that legalizes pharmacists prescribing emergency contraceptives and encourages follow-up with the patient’s personal physician. *(A-99, Revised A-11)*

OMA recognizes unintended pregnancy and poor birth outcomes as preventable public health issues, and that family planning and preconception care are a key component of primary care medicine. The OMA endorses the Oregon Foundation for Reproductive Health’s campaign, in an effort to increase preconception and contraceptive care without a mandate. The initiative encourages all primary care physicians or other members of the health care team to routinely ask women age 18-50 (if applicable) “Do you intend to become pregnant in the next year?”, and provide appropriate services or referrals as indicated, including screening for pregnancy-related risk factors, provision of prenatal vitamins, complete contraceptive counseling, and counseling on Sexually Transmitted Infections (STI) prevention. Furthermore, the OMA encourages all primary care physicians or other members of the health care team talk to adult male patients about sexual responsibility. *(A-11; Approved Oct.-16; Reaffirmed Feb.-19)*

Adopted at the annual House of Delegates, 2011.
Approved by the Board of Trustees for referral to the AMA, October 2016.
Reaffirmed policy by the Board of Trustees and approved for referral to the AMA, February 2019.

EMERGENCY CONTRACEPTION MEDICATIONS

OMA supports dispensing of over-the-counter emergency contraception medications. *(A-01, Revised A-11)*

EXTENDING POSTPARTUM MEDICAID COVERAGE TO TWELVE MONTHS

The OMA supports the extension of Medicaid to twelve months postpartum. *(Sept. 2020)*

MATERNAL MORTALITY AND MORBIDITY AS A PUBLIC HEALTH CRISIS

OMA supports the following policy statements on Maternal Mortality and Morbidity as a Public Health Crisis:

1. That our OMA advocates for a standardized, inclusive, and uniform definition of maternal mortality and morbidity, along with the adoption of federal standards for the collection and reporting of race and ethnicity data, to accurately measure and monitor outcomes and reduce disparities.

2. That our OMA advocates for additional research into the causes, impacts, and severity of maternal morbidity to inform evidence-based interventions.

3. That our OMA advocates for legislation to improve maternal health during and after pregnancy, with a focus on Black, American Indian and Alaska Native (AIAN), and Native Hawaiian and Pacific Islander (NHPI) maternal health, including increased funding for Medicaid programs for up to a year postpartum.

4. That our OMA advocates for formation of medical-legal partnerships and broader policy changes that address social and structural determinants of health, including economic justice, housing stability, and equitable access to health care, to improve maternal health outcomes.

5. That our OMA advocates for expanded funding and access to mental health services and substance use treatment programs, with a focus on culturally responsive health navigation staff.

6. That our OMA recognizes the importance of ongoing anti-racist education for learners and clinicians on cultural humility, implicit bias, and systemic racism to improve maternal health outcomes for Black, AIAN, and NHPI patients, as well as all Oregonians. This extends to fostering an anti-racist culture of learning, belonging, accountability, and continuous improvement among all individuals involved in the delivery of healthcare.

7. That our OMA advocates for the meaningful engagement of patients and communities with lived experiences of marginalization in the development of research, policies, and clinical practices to improve maternal health equity.

8. That our OMA supports policies and initiatives aimed at recruiting, retaining, and advancing health care professionals from racial and ethnic communities underrepresented in medicine to improve maternal health outcomes.

9. That our OMA acknowledges the role of systemic racism and bias in preventable maternal mortality and morbidity and supports reforms to eliminate these disparities. See Appendix X
(*May 2025*)

MATERNAL MORTALITY REVIEW COMMITTEE

OMA supports the establishment of a Maternal Mortality Review Committee in Oregon through appropriate legislative and/or regulatory processes. (Oct.-17)

POSTPARTUM CONTRACEPTION REIMBURSEMENT

OMA supports reimbursement by all insurance carriers for Long-Acting Reversible Contraception (LARC) devices and insertion initiated at the time of the woman's admission for delivery, and OMA supports the inclusion of contraceptive services after delivery for women on Citizen Alien Waived Emergency Medicaid (CAWEM). *(October 2016)*

PREGNANCY

OMA strongly supports family-oriented in-hospital births and encourages public education regarding birthing alternatives. *(A-80, Reaffirmed A-11)*

ONE KEY QUESTION

The OMA re-affirms its position on One Key Question and supports the AMA Delegation introducing the resolution at the upcoming AMA House of Delegates Meeting in June. *(February 2019)*

PROMOTION OF HUMAN DIGNITY AND ACCESS TO REPRODUCTIVE HEALTH CARE FOR INCARCERATED WOMEN

The OMA endorses the standards recommended by the American College of Obstetricians and Gynecologists for incarcerated women's reproductive healthcare, as outlined in the ACOG Committee for Health Care for Underserved Women's opinion No. 830, "Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals."

The OMA, in collaboration with other stakeholders and partners, will advocate for reforms to promote the provision of high-quality, trauma-informed, gender-specific reproductive health care in correctional facilities, to include, but not limited to:

1. Allowing incarcerated women to refuse a custody officer from being present during their breast and/or pelvic exams
2. Requiring law enforcement officers who are present during any health visit involving a breast and/or pelvic exam to comply with HIPAA privacy protections
   (*Feb. 2022*)

SEXUALLY TRANSMITTED INFECTIONS

OMA recognizes that physicians and physician assistants are an integral resource and vehicle for sexually transmitted infection (STI) education and called upon physicians and physician assistants to make a special effort, through their county medical societies, to avail themselves of educational materials on STI that they could provide to their patients. Physicians and physician assistants are encouraged to take an active role in their communities regarding STI education, acting as resources for teachers in their communities as well. *(Revised A-11; Amended Feb. 2023)*

SUPPORT FOR GENDER-AFFIRMING AND LGBTQ+ HEALTHCARE

1. The OMA adopts the following policy statement and places in *Where We Stand*:

Support for Gender-Affirming and LGBTQ+ Healthcare

OMA recognizes the health and social disparities and structural barriers that affect the delivery and receipt of care for LGBTQ+ people, and OMA supports policy that advances and improves LGBTQ+ healthcare in the state.

2. The OMA adopts the following recommendations regarding Support for Gender-Affirming and LGBTQ+ Healthcare and places into *Where We Stand*:

GLMA[1]: Health Professional Advancing LGBTQ+ Equality
Adapted Principles Related to Supporting LGBTQ+ Health

Number 1 Support the 2016 United Nations Political Declaration on Ending AIDS to remove all forms of HIV-related travel restrictions. Travel restrictions based on real or perceived HIV status prevent people from accessing HIV services and propagate stigma and discrimination.

Number 2 Support access to medical, mental health, social, and educational services for people who engage in sex work, to improve the health of people who engage in sex work and help prevent transmission of HIV and other sexually transmitted infections.

Number 3 Oppose involuntary HIV testing of people in prisons and other custody as they take away the right of the individual to make their own healthcare decisions.

Number 4 Support the use of syringe services to be available throughout the health system to reduce HIV and viral hepatitis transmission, and urge legislative bodies to enable the legalized availability of sterile syringes and needles and safe injection sites. These programs do not increase addiction but in fact facilitate connection to substance use disorder treatments. Education programs for needle sterilization should be widely disseminated through all local substance abuse treatment programs, including street outreach.

Number 5 Recommend that primary care expansion programs be inclusive of clinicians and patients who identify as LGBTQ+ and/or BIPOC*, addressing the health disparities and culturally specific needs of these populations. *BIPOC; Black, Indigenous, People of Color.

Number 6 Resolve to promote research and education about factors that influence the health of LGBTQ+ youth, to promote positive interventions for these youth, and to establish liaisons with other organizations that deal with the health and wellbeing of this population.

Number 7 Support the full civil rights and benefits of marriage regardless of the sex and/or gender of the spouses, and further support the full civil rights and benefits for domestic partners regardless of the sex and/or gender of the domestic partners.

Number 8 Clinicians follow evidence-informed, gender-affirming, patient-centered guidelines in the routine practice of medicine.

Number 9 Promote routine cervical cancer screening as an essential component of preventative health care. Recommend that LGBTQ+ individuals with cervixes are offered trauma-informed, body-inclusive, and culturally-competent cervical cancer screenings that are in accordance with the latest evidence and current clinical guidelines. Understand that a disproportionate percentage of LGBTQ+ identified people with cervixes do not receive cervical cancer screening, often because of

[1] GLMA: Health Professionals Advancing LGBTQ+ Equality does not generally spell out the acronym “GLMA” as part of the name since adopting a more inclusive organizational name.

stigma, clinician misconceptions about risk, and trauma associated with invasive speculum exams. Recommend that clinicians practice person-centered care by utilizing a shared decision-making model including review of the differing accepted screening tools (e.g., self-collected primary HPV swab, clinician-performed speculum exam with cytology swab) and timelines. Clinicians should affirm the right to bodily autonomy and avoid pressuring patients to comply with screening recommendations. Encourage the leading medical organizations to acknowledge the unique needs of LGBTQ+ people when creating and updating guidelines, support expanded research into trauma-informed pelvic care, and provide evidence-based clinical resources for ensuring cervical health in patients unable to tolerate pelvic exams.

Number 10 Support federal, state, county, and municipal legislation and policies that acknowledge the need for all students to learn about all aspects of human sexuality, promote respect for all people including LGBTQ+ persons, and provide for support and social opportunities for LGBTQ+ youth.

Number 11 Oppose the behavioral and psychological interventions known as “reparative” or “conversion” therapies that attempt to change sexual orientation or gender identity.

Number 12 Call for universal immunization of anyone using the anus as a sexual organ for both hepatitis A and hepatitis B. This is in accordance with the CDC and Advisory Committee on Immunization Practices (ACIP) recommendation of immunization for hepatitis A and B for men who have sex with men and extends it to be more comprehensive based on behavior. Urge continued population education and state and federal government funding to reduce barriers to vaccination access. Urge all public and private insurers and third-party payors to cover the full cost of hepatitis A and hepatitis B vaccinations.

Number 13 Urge federal government agencies, community-based programs, and private entities to increase funding, research, treatment, and support services to address substance use in LGBTQ+ communities. Seek to create collaborative relationships with other organizations and healthcare providers to improve substance use outcomes among LGBTQ+ individuals.

Number 14 Discourage the use of nicotine and further call on government agencies to fund research, support effective prevention and cessation programs, and implement legislation and regulations focused on reducing or eliminating nicotine use within LGBTQ+ communities. Calls on businesses that promote nicotine use to cease targeted marketing efforts directed at the LGBTQ+ community, particularly LGBTQ+ youth, and to support cessation and harm reduction programs. Encourage LGBTQ+ community leaders and organizations to cease seeking financial support from nicotine producing companies and providing such companies with marketing platforms that serve to promote and continue nicotine use by LGBTQ+ people. Support the education and training of all healthcare clinicians, across disciplines, to allow for culturally- competent, evidence-based, care and support rooted in cultural humility of LGBTQ+ people to promote nicotine use cessation.

Number 15 Support funding a broad array of proven approaches to prevent sexually transmitted infections among adolescents, including teaching of safer sexual practices and LGBTQ+-inclusive education; and recognize that there is an inherent danger in funding unproven programs, such as abstinence-only programs, at the expense of other approaches that have been proven effective.

Number 16 Affirm that patients have the right to nonjudgmental sexual healthcare and the right to access the full spectrum of reproductive healthcare services, including contraception, fertility treatment, sterilization, and abortion. Affirm the right of all providers of reproductive health care to do their work free of harassment, intimidation, and danger.

Number 17 Support the ability of LGBTQ+ people to adopt children or serve as foster parents free of any discrimination based upon sexual orientation or gender identity. Call on government agencies, legislative bodies, and the courts to guarantee the rights of LGBTQ+ people to be adoptive or foster parents free from any standard that differentiates their qualifications to be parents from those qualifications applied to heterosexual or cisgender candidates. Urge that agencies providing adoption and foster care services educate themselves about LGBTQ+ issues and adopt nondiscrimination policies.

Number 18 Call upon media and organizational representatives to accurately report the state of the evidence and scientific literature and to stop citing uncreditable sources that perpetuate harmful myths about LGBTQ+ people being a threat to children based on sexual orientation or gender identity.

Number 19 Urge that All State Surveys, the Census bureau, health registries, and all-payer claims databases, as part of other demographic questions asked such as race and ethnicity, should include demographic questions about Sexual Orientation and Gender Identity (SOGI). Gender identity should include two separate questions asking sex assigned at birth and gender identity. These questions should be evidenced-based to assure validity, be anonymous, encourage but not require disclosure, and be culturally competent. Electronic Health Records should similarly ask questions about SOGI which are evidenced-based to assure validity, encourage but not require disclosure, and be culturally competent. These questions should be introduced into a health system along with educating those who will use the information on clinical implications, how to behave in a culturally competent manner, and how to keep the information confidential.

Number 20 Advocate for the discontinuation of a lifetime deferral for blood donation by men who have sex with men (MSM). Recommend that any deferment of blood donation should be based on current medical screening practices for bloodborne pathogens and the sensitivity, specificity, and reliability thereof. Support the development of an individual risk assessment that screens all potential blood donors for increased risk of sexually transmissible bloodborne pathogens, regardless of the gender of the potential donor or their sexual partners. Recommend continued vigilance in screening and monitoring of the current blood supply and future blood donations for the presence of bloodborne pathogens using up-to-date scientific methods.

Number 21 Recognize that ending the HIV/AIDS epidemic includes:

a. Focusing on culturally competent approach to LGBTQ+
    i. Identifying intersectional identities (LBGTQ+, BIPOC*, mental health, and substance use) associated with HIV transmission to ensure all social determinants of health are addressed in order to optimize overall health
    ii. Increasing research that is more inclusive of sexual and gender diversity
    iii. Increasing attention to identification of risk factors not determined by sexual and gender conventions
    iv. Destigmatization of HIV infection and structural change to eliminate disparities among minorities
    v. Civil rights protections of individuals affected by HIV including those granted under the Americans with Disabilities Act (ADA)
    vi. Access to care for prevention and treatment of HIV which is affirming and free of stigma
b. Diagnosing all people living with HIV as early as possible including
    i. Routine, opt-out based HIV testing, free of stigma, to diagnose all people with HIV as early as possible
    ii. Routine perinatal HIV testing and increased funding, research, and education for perinatal HIV prevention
c. Access to HIV services including treatment and prevention free of stigma for all people regardless of immigration status inclusive of black, indigenous, and people of color
    i. Rapid and patient-centered initiation of effective ART directly after HIV diagnosis to achieve sustained viral suppression and minimize transmission
    ii. Increasing awareness of the ability to eliminate transmission risk through viral suppression (i.e. undetectable = untransmittable) while ensuring that the decision to initiate antiretrovirals is informed and autonomous
    iii. Support of local, state, and federal funding of HIV services, care, housing, and research
    iv. Representation of women (cis- and transgender) and BIPOC populations at all local, state, and federal levels of HIV research, education, and planning; addressing sexual transmission, perinatal transmission, parenteral transmission, childcare, and family care issues as they relate to women at every level
    v. Representation of youth and youth advocates at all local, state, and federal levels of HIV research, education, policy development, and planning; addressing healthy decision making, sexual transmission, treatment options, and other areas of concern as they relate to youth.
    vi. Increasing HIV workforce capacity through scholarships and student loan repayment
d. Increasing access to patient-centered, evidence based, prevention of new HIV transmissions, including PrEP, PEP, and syringe services programs
e. Surveillance, reporting, and response to HIV outbreaks.

Number 22 Recommend that sexually active people be allowed to self-collect rectal, pharyngeal, and vaginal/front-genital swabs for the purpose of PCR-based sexually transmitted infection testing. Recommend that commercial and state laboratories create protocols that allow patients to self-collect swab specimens on site. Recommend that all outpatient clinics allow patients to choose whether self-collected or clinician-collected swabs are right for them, which is important in forming an approach sensitive to the unique sexual health needs of LGBTQ+.

Encourage leading medical organizations to consider the specific importance of self-collect swabs to LGBTQ+ when creating and updating guidelines.

Number 23 Support athletes who are transgender and seek to participate on athletic teams or in athletic competition aligned with their gender identity. For athletes, who identify as non-binary and seek to participate in athletics where competition remains gendered, support their ability to designate the competition in which they desire to participate. Call on all athletic federations, leagues, and athletic associations to remove any participation policies which include blanket prohibitions against transgender athletes from competing aligned with their gender identity. Further, note that the ability to participate in athletics is fundamental to promoting the overall health and well-being of transgender people. Accordingly, call on all local and state administrators, legislators, and judges to support inclusive policies and to reject any attempt to prohibit a transgender youth from participating in interscholastic competitions, whether in elementary, high school, or collegiate sports programs that align with their gender identity.

Number 24 Recommend that patients and parents/caretakers are provided a comprehensive explanation of risks and benefits to surgical/medical intervention for Differences of Sex Development (DSD), as well as all alternatives to treatment, including postponement of interventions; recommends delay of any surgical interventions and gender-related medical interventions for DSD that are not deemed medically necessary until the patient can provide informed consent/assent to these interventions; encourages additional comprehensive retrospective and prospective biopsychosocial research on the long-term outcomes of patients born with differences of sex development; recommends that the development and execution of research should involve, where available, the input of community representatives, psychiatrists, and other mental health practitioners from the intersex and DSD communities; and recommends that facilities that provide genital surgical interventions and gender-related medical interventions to patients with DSD adopt a multidisciplinary model to patient care that includes input from mental health specialists, medical and surgical specialists, bioethicists, and community/peer support organizations to deliver comprehensive biopsychosocial treatments that support all patients, their families, and any other caretakers.

Number 25 Recognize that:

a. All intersex people have the right to make their own decisions affecting their bodily integrity, physical autonomy, and self-determination.
b. Medically unnecessary treatment, surgeries, and sterilizations of intersex people should not occur without said intersex person's full informed consent.
c. Intersex people and the families of children born with intersex traits should have access to non-pathologizing psychosocial and peer support.

Number 26 Support the development and implementation of policies and laws that limit unnecessary disclosure of confidential medical records, especially as it pertains to sexual orientation, sexual behavior, gender identity, anatomic status, or health status (including HIV status).

Number 27 Consider therapeutic treatments, including hormone therapy, mental health therapy, vocal therapy, hair removal, and gender- affirming surgeries, as medically

necessary for the purpose of gender-affirmation or the treatment of gender dysphoria or gender incongruence and which should be covered by public and private insurance plans.

GLMA: Health Professional Advancing LGBTQ+ Equality
Adapted Principles Related to LGBTQ+ Healthcare Needs

Number 28 Recognize the particular challenges experienced by transgender and gender non-conforming (TG/GNC) persons with regard to boarding and privacy in hospital, assisted living, nursing facility, inpatient treatment units, and other healthcare settings including harassment, assault, medical mistreatment, and delay or denial of necessary care.

Number 29 Healthcare facilities co-board residents by gender should be encouraged to respect the gender identification of TG/GNC persons and a patient should not be excluded from gender-segregated units or housing based on sex, sex assigned at birth, sexual identity, or gender identity.

Number 30 Support the facilitation of requests for private or non-gendered rooming for TG/GNC patients, due to an increased burden of harassment and mis-treatment in healthcare settings.

Number 31 Support room assignments based on an individual's self-identified gender, regardless of their surgical history, genitalia, legal sex, legal name, sex assigned at birth, or physical appearance.

Number 32 Recognize the significant delays experienced by TG/GNC persons related to boarding, including for mental health admission, and the contribution of prolonged boarding to negative mental health outcomes in particular, and call for policies and actions to reduce healthcare delays related to sex, sexual orientation, and/or gender identity.

Number 33 Support free and equal access to both non-gendered restroom facilities and restroom facilities aligned with individual gender in healthcare settings. TG/GNC persons should not be restricted in using facilities congruent with their gender, and should additionally have access to unisex restroom facilities. Patients should be protected from harassment, abuse and interference in using publicly accessible restroom facilities in healthcare settings.

Number 34 Recommend free provision of menstrual products in all restroom facilities in healthcare settings.

GLMA: Health Professional Advancing LGBTQ+ Equality
Adapted Principles Related to Gender-Affirming Care

Number 35 Support gender-affirming social and medical interventions as management options for transgender and gender non-conforming (TG/GNC) persons experiencing gender dysphoria or distress related to gender incongruence in alignment with the American Medical Association, Endocrine Society, American Academy of

Pediatrics, American Psychological Association, and countless other medical professional associations.

Number 36 It is recognized that gender-affirming medical and surgical interventions can have lifesaving potential. Surgeries of cosmetic relevance done for gender-affirming purposes are reconstructive and not cosmetic in nature and indication. These services should be covered by and not selectively excluded by health insurance payors. Such services might include but are not limited to hair removal, facial reconstructive surgeries for feminizing or masculinizing purposes, and speech therapy.

Number 37 Assert that gender-affirming medical interventions are not by definition experimental or investigational treatments.

Number 38 Recognize that gender-affirming care as a highly individualized field that depends upon a patient-centered approach, and that a given TG/GNC person may want only some specific interventions or no interventions. Oppose methodologies of care that impose arbitrary and onerous requirements on transgender people to access medical interventions or require specific interventions as a condition of documentation changes, restroom use, or other basic aspects of daily living and social affiliation.

Number 39 Oppose local, state, or federal, legislative, executive, or judicial attempt to criminalize, penalize, or otherwise interfere with the provision of evidence-based, medically necessary, gender-affirming medical care to transgender and gender-diverse youth.

Number 40 Call on legislators, judges, and executive branch officers to cease attempts to make the provision of gender affirming care to youth a crime under the penal statutes of a jurisdiction and to cease attempts through non-criminal penalties such as threats to a clinician's professional licensure or a supportive parent's or legal guardian's custodial rights to deter the provision of evidence-based gender-affirming care.

OMA Principles Related to LGBTQ+ Healthcare Needs

Number 41 Support requests for a healthcare professional of a particular gender and/or a healthcare professional who is a member of the LGBTQ+ community when feasible and in line with Title IX, equal employment opportunity commission and other relevant institution-specific anti-discrimination policies.

Number 42 Note particular challenges in aging and senior care of relevance to Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) persons and compounded personal suffering and health impacts related to hostility, indifference and lack of support of LGBTQ+ persons in assisted living, nursing home and memory care facilities, and affirm the need and the right of elderly LGBTQ+ persons to friendly and safe living environments.

AMA Adapted Principles Related to Preventing Anti-Transgender Violence

Number 43 Will partner with other medical organizations and stakeholders to increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths.

Number 44 Will advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated.

Number 45 Will advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated.

Number 46 Will advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust.

Number 47 Will advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

OMA Principles Related to Protection From Harassment and Harm When Accessing Care

Number 48 Support protections for individuals accessing gender-affirming care and/or LGBTQ+-related healthcare.

Number 49 Not tolerate violence, acts of force, threat of force, intimidation, property damage, or related preventing access to gender-affirming and/or LGBTQ+-related healthcare.

Number 50 Support penalties for acts of force, threats, intimidation, property damage, or physically preventing access to gender-affirming and/or LGBTQ+-related healthcare.

Number 51 Support protection of the physical space around health facilities providing gender-affirming and/or LGBTQ+-related healthcare.

Number 52 Support investment in and promotion of community support mechanisms to promote the safety of people seeking access to gender-affirming and/or LGBTQ+-related healthcare.

Number 53 Support protections of patient medical information and data from investigators from other states, including the records of individuals who travel from a state where gender-affirming and/or LGBTQ+-related healthcare is restricted.

GLMA: Health Professional Advancing LGBTQ+ Equality
Adapted Principles Related to the Needs and Rights of LGBTQ+ Youth

Number 54 Affirm that pediatric patients have the right to nonjudgmental developmentally appropriate sexual healthcare based on the standard of care. This affirmation also includes the right of all licensed clinicians providing reproductive health care to do their work free of harassment, intimidation, and danger.

Number 55 Recommend and encourage all healthcare facilities adopt specific guidelines and policies to ensure LGBTQ+ youth receive safe, culturally-competent care, including room assignments.

Number 56 Support and encourage state, county, and municipal legislation and policies that acknowledge the need for all youth to learn about all aspects of human sexuality, that promote respect for all people including LGBTQ+ persons, and that provide for support and social opportunities for LGBTQ+ youth.

Number 57 Oppose the behavioral and psychological interventions known as “reparative” or “conversion” therapies that attempt to change sexual orientation or gender identity.

AAP Adapted Principles Related to the Needs and Rights of LGBTQ+ Youth

Number 58 Recommend that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of youth while maintaining confidentiality and avoiding duplicate charts as appropriate.

OMA Principle Related to the Needs and Rights of LGBTQ+ Youth

Number 59 Acknowledge that formation of gender identity and sexuality, including LGBTQ+ identities, is a normal part of pediatric development.

(June 2023)
See also Appendix U

PROTECTING PATIENTS AND THE PRACTICE OF MEDICINE IN A TIME OF DISINFORMATION ABOUT GENDER-AFFIRMING CARE

The Oregon Medical Association (OMA) adopts the following policy statements and places in Where We Stand:

Protecting Patients and the Practice of Medicine in a Time of Disinformation About Gender-Affirming Care

Principle 1: The OMA commitment to providing universal health care access means no subset of patients should be restricted in their access to health care, including the transgender and gender non-conforming community.

Recommendation:

1. Advocate to protect access to healthcare for transgender and gender non-conforming patients, as is done for other groups who have been subject to discrimination historically.

2. Support physicians and other clinicians who are working to maintain access to healthcare for all, including the transgender and gender non-conforming community.

3. Defend access to gender affirming care and other healthcare for marginalized populations when their access is threatened by legislative, judicial, or executive action.

Principle 2: The OMA recognizes that physician and physician assistant (PA) engagement in the spread of disinformation or misinformation around gender affirming care has the potential to cause harm to transgender and gender non-conforming patients and is a violation of professionalism. The special role of clinicians in society imposes additional responsibilities. Breaches of professionalism can present significant risks to patients, the medical community, and the public.

Recommendation:

1. Recognize that physicians and PAs have a professional obligation to protect patients and the public from disinformation and misinformation by utilizing their education and access to clinical information to recognize, condemn, and correct it.

2. Support existing Oregon Medical Board policy with respect to the spread of harmful false or misleading information, including that regarding gender affirming care.

Principle 3: The OMA recognizes that physicians and PAs have an obligation to uphold patient privacy, including information about patients' sexual orientation, sexual behavior, gender identity, and anatomic status, to maintain a safe, affirming healthcare environment.

Recommendation:

1. Consistent with longstanding OMA policy and HIPAA, support the development and implementation of policies and laws that prevent disclosure of confidential medical information and records. Advocate for legislative, judicial, and executive actions that honor patient privacy, including privacy related to gender identity, and anatomic status.

2. Support a patient's right to make autonomous decisions regarding their healthcare, using the best available scientific and medical evidence. Protect the integration of a patient's knowledge of their values, needs, and identity (including their gender identity and anatomic status) into the healthcare decision-making process.

Principle 4: The Oregon Medical Association (OMA) actively opposes government actions that would criminalize or otherwise limit gender affirming medical care provided by physicians and PAs that is within the accepted standards of medical practice.

Recommendation:

1. Actively oppose legislative, judicial, and executive actions that restrict the practice of medicine and harm the relationship between the patient and clinician, including when access to gender affirming care is affected.

2. Acknowledge that the medical profession is best positioned to establish appropriate standards for the practice of gender affirming care, based on the incorporation of scientific and medical research; consideration of the purpose, identity, values, and ethical standards of the profession; and accounting for the autonomy of transgender and gender non-conforming people.

   See Appendix W
   (June 2024)

TEEN PREGNANCY

[SEE – CHILD / ADOLESCENT HEALTH]

UPDATING LANGUAGE REGARDING SEXUALLY TRANSMITTED INFECTIONS IN ALIGNMENT WITH CDC GUIDELINES

The Oregon Medical Association revises current policy language within "Where We Stand" to replace "sexually transmitted disease" with "sexually transmitted infection" and add reference to physician assistants. *(Feb. 2023)*

SUBSTANCE USE DISORDER

ADVANCING COMPREHENSIVE AND EVIDENCE-BASED SUBSTANCE USE DISORDER TREATMENT IN OREGON

The OMA supports a multifaceted evidence-based approach to substance use disorder treatment in Oregon, including but not limited to:

- Medically assisted detoxification
- Evidence-based pharmacotherapies
- Comprehensive mental health treatment for patients with additional mental health diagnoses
- Harm reduction strategies
- Residential treatment and access to stable housing as part of addiction care
- Treatment and continuity of care for patients in and after incarceration

The OMA will advocate to secure and protect long-term funding that enhances access to substance use disorder treatment, including growth of the workforce to meet the demand for addiction care.

The OMA's Substance Use & Pain Care Task Force work to provide timely and essential expert input toward advocacy efforts for the 2024 and 2025 Oregon state legislative sessions, ensuring physician voices are influential in the critical discourse on substance use disorder management in Oregon. (*February 2024*)

OPIOID PRESCRIBING GUIDELINES TASK FORCE

The OMA supports the Oregon Opioid Prescribing Guidelines Task Force in adopting the CDC guidelines for prescribing opioids for chronic pain as the foundation for opioid prescribing for Oregon and encourages the Task Force to further discuss at state, regional, and organizational levels how the guidelines will be disseminated, communicated to patients and providers, and implemented. *(June 2016 – from the floor)*
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

ADVOCACY FOR ADDICTION CARE IN HOSPITALS AND CORRECTIONAL INSTITUTIONS

The OMA advocates for the expansion of hospital-based addiction care throughout Oregon hospitals and correctional institutions, and for programs that lead to a trained healthcare workforce in addiction medicine, and for amplifying research that evaluates the efficacy of hospital-based addiction care models and that shares best practices in hospital-based addiction care in Oregon. (*June 2021*)

EXPANDED ACCESS TO NALOXONE

The OMA supports programs and policies that increase access to naloxone in Oregon, including but not limited to increasing public education and training on naloxone use and harm reduction interventions, removing barriers to accessing clean syringes from pharmacies, and increasing public emergency access to naloxone without needing to visit a pharmacy. (*June 2021*)

PRESCRIBING OPIOIDS

The OMA adopts the following overarching policy regarding prescription opioids, including, but not limited to, the following:

The OMA recognizes the vital role that physicians and physician assistants (PAs) play in the provision of appropriate pain management services including prescribing opioid analgesics for assessed pain.

The OMA supports the shared decision making process between the prescriber and the patient that includes weighing the risks and benefits of starting or continuing opioid therapy.

The OMA supports the education of physicians and physician assistants regarding the proper assessment, referral and treatment of chronic pain as well as strategies to lessen the diversion, misuse, abuse, and unintentional overdose, and death from opioid pain relievers.

The OMA supports continued clinician input into pain management regulations and legislation.

The OMA encourages physicians and physician assistants to use all available risk assessment tools to improve safety in pain management as is fitting to their practice. The OMA endorses:

- Continued research and adoption of evidence-based guidelines for the safe treatment of chronic pain
- Increased access to non-opioid modalities that are appropriate for pain care and covered by insurance
- The regular use of the Prescription Drug Monitoring Program (PDMP)

Monitoring Program (PDMP)

- Efforts to make the Prescription Drug Monitoring Program (PDMP) more easily accessible to prescribers.

- Regular adherence monitoring and evaluation of a patient's opioid therapy
- Increased access to comprehensive addiction evaluation and/or treatment for individuals diagnosed with opioid use disorder

Finally, the OMA endorses public and community education for greater awareness of the risks of opioid prescriptions and options for pain management.

The OMA will work in collaboration with other organizations including other medical associations to address the issue of opioid safety in a holistic manner that ensures patient safety and wellbeing remain at the forefront of prescribing practices. *(June 2016)*

OREGON ACUTE OPIOID PRESCRIBING GUIDELINES 2017-2018 RECOMMENDATIONS

The OMA supports the Oregon Acute Opioid Prescribing Guidelines 2017-2018 Recommendations published by the Oregon Health Authority. https://www.oregon.gov/obnm/rules/AcuteOpioidPrescribingGuidelines.10.2018.pdf, also on file *(June 2019*)

OREGON PREGNANCY AND OPIOIDS WORK GROUP 2017-2018 RECOMMENDATIONS

The OMA supports the Oregon Pregnancy and Opioids Work Group 2017/18 recommendations (https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/Oregon-Pregnancy-and-Opioids-Recommendations.pdf, *also on file*):

Primary prevention (for all women)

1. Ask all women of reproductive age about their pregnancy intentions prior to medication-assisted treatment (MAT) for an opioid use disorder (OUD).
2. Ask all pregnant women and women seeking pregnancy or preconception care about opioid use.
3. For all pregnant women without an OUD, avoid prescribing opioids when possible but, if necessary, do so with safeguards in place.
4. Prevent opioid overdose.
5. Upon discharge after a delivery, encourage all women without an OUD who need ongoing pain treatment to use non-opioid therapies (i.e., NSAIDs). If opioids are indicated, they should receive a limited number of opioid pills to last until a scheduled follow-up visit and no more than seven days of treatment.

Secondary Prevention (for women with an opioid use disorder and their infants)

6. Coordinate care for pregnant and parenting women with an OUD.
7. Manage OUDs during pregnancy by following evidence-based approaches.
8. Include additional screenings and services when caring for pregnant women with an OUD.
9. Provide appropriate pain control for women with an OUD during labor.
10. Provide necessary postpartum services and support for women with an OUD.
11. Encourage breastfeeding for women with an OUD on MAT.

System and Policy Recommendations

12. Closely monitor an infant born to a mother who used opioids during pregnancy. Manage care with a standardized protocol for the assessment and treatment of infants at risk for neonatal abstinence syndrome (NAS). System and policy recommendations

13. The Oregon Health Authority, in partnership with the Oregon Maternal Data Center, should implement a surveillance strategy for in utero opioid exposure and NAS. The strategy should be mindful of any unintended negative consequences and seek a balance between patient confidentiality and the state's ability to truly understand the scope of the problem.
14. Oregon health care leaders and policy makers should work to advance systems change that supports families affected by OUD.

(Sept. 2018)

OREGON OPIOID TAPERING GUIDELINES

The OMA adopts the Oregon Opioid Tapering Guidelines Recommendations for Individualized Care to Reduce Harm From Opioid Use January 2020. (February 2021) https://www.oregon.gov/omb/Topics-of-Interest/Documents/Oregon-Opioid-Tapering-Guidelines.pdf

AMA 2019 OPIOID TASK FORCE RECOMMENDATIONS

The OMA adopts the AMA 2019 Opioid Task Force Recommendations:

1. Remove prior authorization, step therapy and other inappropriate administrative burdens or barriers that delay or deny care for FDA-approved medications used as part of medication assisted treatment (MAT) for opioid use disorder (OUD).

2. Support assessment, referral and treatment for co-occurring mental health disorders as well as enforce meaningful oversight and enforcement of state and federal mental health and substance use disorder parity laws.

3. Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs.

4. Support maternal and child health by increasing access to evidence-based treatment, preserving families, and ensuring that policies are non-punitive.

5. Support reforms in the civil and criminal justice system that help ensure access to high quality, evidence-based care for OUD, including MAT. See Appendix L (*February 2020*)

   (February 2020)

REMOVAL OF BIASED LANGUAGE IN THE OMA "WHERE WE STAND" SUBSTANCE USE SECTIONS

The OMA adopts the use of non-biased language in the OMA "Where We Stand" document and will review the document to identify and change wording to trauma-informed, non-discriminatory language in substance use sections. The OMA shall use vetted resources, including but not limited to the National Institutes of Health NIDA's "words matter guidance," when working on substance use issues or policies. (*June 2021*)

SUBSTANCE ABUSE - DEFINED

Substance abuse and addiction are major public health problems that, when left untreated, account for significant medical, legal, social and financial costs. Addictive disease is a life-threatening affliction and should be treated as such. Physicians and other health care providers should take a leadership role in communities and educational systems in advocating for treatment and prevention of addiction disorders. *(A-06)*

SUBSTANCE ABUSE

The OMA aligns its position on Substance Abuse (SA) with the 21 Objectives and Topics contained in Healthy People 2020 on this topic:
www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=40

SA-1 Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol
SA-2 Increase the proportion of adolescents never using substances
SA-3 Increase the proportion of adolescents who disapprove of substance abuse
SA-4 Increase the proportion of adolescents who perceive great risk associated with substance abuse
SA-5 (Developmental) Increase the number of drug, driving while impaired (DWI), and other specialty courts in the United States
SA-6 Increase the number of States with mandatory ignition interlock laws for first and repeat impaired driving offenders in the United States
SA-7 Increase the number of admissions to substance abuse treatment for injection drug use
SA-8 Increase the proportion of persons who need alcohol and/or illicit drug treatment who received specialty treatment for abuse or dependence in the past year
SA-9 (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department
SA-10 Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI)
SA-11 Reduce cirrhorsis deaths
SA-12 Reduce drug-induced deaths
SA-13 Reduce past-month use of illicit substances
SA-14 Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
SA-15 Reduce the proportion of adults who drank excessively in the previous 30 days
SA-16 Reduce average annual alcohol consumption
SA-17 Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities
SA-18 Reduce steroid use among adolescents
SA-19 Reduce the past-year nonmedical use of prescription drugs
SA-20 Decrease the number of deaths attributable to alcohol
SA-21 Reduce the proportion of adolescents who use inhalants

Marijuana-prescribing physicians should be current in their knowledge of marijuana prescribing standards and national and state rules and regulations. See
http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/

Pages/legal.aspx#dojmemo; see also Oregon Medical Association's *Medical-Legal Handbook,* updated each biennium to reflect changes in law. *(A-99) (Revised April-13)*

MARIJUANA

The OMA supports further study into the effects of marijuana use on health and public safety. The OMA will gather and disseminate appropriate information to its members regarding scientific, regulatory, and public health information on the effects, use, and abuse of cannabis. *(October-14)*

The OMA supports efforts to reclassify marijuana from a Schedule I controlled substance to a lower classification that allows for legitimate medical research on benefits and long term effects of marijuana on the health of individuals *(January-15)*

OMA supports the controlling of cannabis advertising to protect the interests of minors. If a Retail Marijuana Establishment sponsor a charitable, sports, or similar event that the Retail Marijuana Establishment shall not engage in advertising at, or in connection with, such an event unless the Retail Marijuana Establishment has reliable evidence that no more than 25 percent of the audience at the event and/or viewing advertising in connection with the event is reasonably expected to be under the age of 21. *(June-17)*

METHAMPHETAMINES

OMA supports legislation at the state level to declare the use or manufacture of methamphetamines a public health issue with all the reporting and tracking procedures associated with other public health issues *(A-05)*

STEROIDS (ANABOLIC STEROIDS)

OMA recognizes "that the overwhelming source of steroids used for medically inappropriate purposes is through illicit channels" and that "enforcement efforts must be enhanced in this arena." OMA also acknowledges "that it is appropriate that vigorous steps be taken to detect and reduce those limited instances where steroids are supplied for non-medical purposes through prescribing practitioners." *(A-89, Reaffirmed A-11)*

OMA encourages the AMA to propose medical and public policy which will, to the extent that prescribing practitioners may contribute to this problem, serve to reduce the availability of anabolic steroids for purposes for which they are not medically indicated. OMA should develop educational programs intended to discourage the use of anabolic steroids by athletes, particularly teenagers and young adults. *(A-89, Reaffirmed A-11)*

WORKFORCE ISSUES

COLLECTIVE BARGAINING TASK FORCE

The OMA President will name a task force to explore the collective bargaining and unionization of Oregon physicians and physician assistants and report back to the February 2024 Board of Trustees. The task force report to the Board of Trustees should include, but not be limited to, an environmental scan of current practices with respect to collective bargaining for physicians and physician assistants, interviews with member or non-member physicians and physician assistants currently working under collective bargaining agreements, a review of ethical standards regarding worker strikes or work stoppages, and viable alternatives to collective

bargaining to address employment issues unrelated to compensation such as working conditions, burnout resources and patient safety advocacy. (*Sept. 2023*)

SUPPORT FOR PHYSICIANS AND PHYSICIAN ASSISTANTS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION

The OMA supports the right of physicians and physician assistants to engage in collective bargaining, including physician unionization, and supports the expansion of the numbers of physicians and physician assistants eligible for that right under state and federal law. The OMA will create materials to assist and direct physicians and physician assistants when pursuing collective bargaining and unionization, ensuring their rights are protected and upheld. And, the OMA will bring a resolution to the American Medical Association (AMA) seeking an updated study of opportunities for the AMA or other physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (*Sept. 2023*)

INCREASING VACCINATION RATES AMONG HEALTHCARE WORKERS AND FIRST RESPONDERS

The OMA supports working with other stakeholders to advocate that the Oregon Health Authority take immediate action and issue a mandate requiring that all health care and long-term care employers, first responder organizations, and correctional institutions require vaccination for employees if they provide reasonable accommodations for those unable to receive the vaccine for medical reasons. The OMA also supports collaborating with other stakeholders to work for amending or repealing ORS 433.416 (3) and 433.407 (3) to allow health care and long-term care facilities, first responder organizations and correctional institutions to require vaccination for employees if they provide reasonable accommodations for those unable to receive the vaccine for medical reasons. (*Oct. 2021*)

OREGON MEDICAL ASSOCIATION POLICY STATEMENT REGARDING PHYSICIAN WORKFORCE

Access to primary and specialty health care services for all Oregonians requires an adequate number of health care workers to achieve universal coverage. The goal of health care workforce planning is to match the supply with the current and anticipated future need for health care services. Oregon suffers from a health care workforce shortage affecting all areas of the state. The Oregon Medical Association advocates for an increase in physician supply. Realizing that the “marketplace” for physicians is national in scope, continued advocacy efforts will be necessary to improve the practice environment essential to attract and retain adequate numbers of physicians in the state. (A-07)

The following principles will guide OMA’s advocacy efforts in health care workforce planning:

1. The OMA is committed to supporting the development and retention of an adequate number of well-educated physicians in all specialties to meet anticipated health and health care needs of all Oregonians.

2. To enhance access to care, workforce planning should utilize data on all aspects of the health care system, including projected demographics of physicians and the population, as well as the number and roles of other health professionals.

3. OMA encourages and supports collaborative efforts with the Oregon Board of Medical Examiners and other organizations in the collection of physician workforce data in sufficient detail to describe current physicians' practice activities.

4. OMA will be integrally involved in any healthcare workforce planning efforts sponsored by federal or state governments, or by the private sector.

5. OMA will support improvement in the practice environment and work actively to influence government policy to attract and retain adequate numbers of physicians and an appropriate specialty mix to meet the needs of the entire state.

6. OMA will promote the distribution of physicians of all specialties to rural Oregon, work to reduce barriers that inhibit physicians from establishing rural medical practices and create incentives to make practice in rural and underserved areas more attractive.

7. OMA supports efforts to further diversify the physician population to reflect the diversity of Oregon's citizenry.

GENDER EQUITY IN THE HEALTHCARE PROFESSION

The OMA supports gender equity in the healthcare profession. As such, the OMA shall advocate for gender equity in physicians' and advanced practice clinicians' compensation and career advancement in all healthcare settings. The OMA shall advocate for industry and organizational policies that promote transparency in defining the criteria for initial and subsequent physicians' and advanced practice clinicians' compensation and career advancement. The OMA shall actively work to confront and eliminate barriers to gender equity in healthcare careers and compensation. And finally, the OMA BOT Policy Committee shall develop a set of actionable recommendations, including an implementation plan. (*June 2019)*

EQUITY AND INCLUSION IN THE HEALTHCARE PROFESSION

The OMA supports equity and inclusion in the healthcare profession. As such, the OMA shall advocate for equity in physicians' and advanced practice clinicians' compensation and career advancement in all healthcare settings. The OMA shall advocate for industry and organizational policies that promote transparency in defining the criteria for initial and subsequent physicians' and advanced practice clinicians' compensation and career advancement. The OMA shall actively work to confront and eliminate barriers to equity in healthcare careers and compensation. And finally, the OMA BOT Policy Committee shall develop a set of actionable recommendations, including an implementation plan. (*June 2019)*

EQUITY TASK FORCE RECOMMENDATIONS

The Equity Task Force recommends:

A. That the OMA adopt the Equity Task Force **Principles** related to equity and inclusion in the medical profession.

    1. The OMA is committed to improving diversity, equity, and inclusion within the medical community and to being an antiracist organization.

2. Patient care benefits when the medical workforce at all levels and in all specialties reflects the diversity of our communities.
3. The OMA affirms the importance of ongoing collection of data and measurements of inequities for impacted groups to create transparency and accountability. We must respect the sensitivity of information collected but must understand the barriers to improved workforce diversity in order to overcome them.
4. The OMA will work to further an inclusive and supportive environment within medicine. Recognizing the burdens to be overcome by individuals facing barriers, the OMA will offer mentorship opportunities and promote policies resulting in active recruitment and support of a more diverse workforce.
5. The OMA recognizes alternate and nontraditional career pathways and supports them as to ensure the growth of and sustain diversity within the workforce and medical community.
    a. Those caring for children, elder family members, or others with increased needs carry burdens and assume responsibilities that should be highly valued in the profession. Taking on this responsibility demonstrates traits congruent with the calling to a life of service in medicine, and retention of these members of our professional community must be a priority. Traditional cultures and systems within the profession must change to allow all members of our professional community to continue to contribute, even when other life burdens make this challenging.
    b. A shift in medical traditions must allow alternate career pathways to include recognition and rewards for work done to further the goals of a diverse workforce.
    c. A shift in culture must also improve the retention, and hence equity, of the medical workforce by recognizing that overcoming barriers is a task to be shouldered by the whole community.
6. The OMA will increase representation of diverse members of the medical community within the organization and its own leadership.
7. The OMA encourages institutions that intersect any part of the pathway in medicine to actively work to increase recruitment to and retention within the medical professions of diverse members.
8. The OMA affirms that physicians and physician assistants deserve equal compensation for the same work as their peers, without regard to gender, race, ethnicity, religion, sexual orientation, and gender identity; or other factors that have placed people at risk of discrimination. This will require further evaluation of salary inequities by race, gender, and other minority status, as well as development of transparent compensation strategies and advancement metrics.
9. The OMA recognizes that improvements in equity in the medical profession will increase the wellbeing, safety, productivity, work satisfaction, and opportunities for medical professionals, as well as positively impact health outcomes for communities, patient access to care, and satisfaction with care.
10. Equity issues in the profession and our society will always be a work in progress. Task Force members recognize that not all facets of equity are thoroughly addressed in this document, and the OMA commits to continuing to advance equity work with attention to additional areas, including but not limited to systemic racism, disability communities, international medical graduates, and religion.

B. That the OMA adopt the Equity Task Force **Recommendations regarding Pathways into Medicine.**
    1. Opportunities for early exposure to medicine and specialty fields and early contact with mentors from diverse backgrounds in medical professions;

2. Institutionally and state funded financial support for students interested in healthcare careers who have a demonstrated financial need to help with preparation for medical school, including support for living expenses and medical school application expenses;
3. Community programs that aim to create a diverse conduit of students to enter health professions, such as underrepresented minority-directed pre-med immersive programs, youth outreach to inspire early interest by medical students and clinicians, and paid opportunities for high school students to work in medical practices with clinicians;
4. Enhanced funding for quality early childhood through high school education and for parental educational and employment opportunities and benefit programs; these are foundational for economic and housing stability and food security for all at-risk families;
5. Holistic admission criteria for medical schools, removing standardized testing as a requirement and prioritizing recruitment from underserved regions;
6. Inclusion of sexual orientation and gender identity as standard demographic variables collected on medical school (AMCAS), residency (ERAS), fellowship, and other employment applications, as well as on licensing applications, academic appointment applications, and professional society surveys to understand whether current recruitment practices effectively achieve diversity goals;
7. Routine evaluation of what demographic variables are collected on medical school, residency, fellowship, and other employment applications, as well as on licensing applications, academic appointment applications, and professional society surveys to consider additional expansion of this list over time as needed to help understand whether current recruitment practices effectively achieve diversity goals;
8. Opportunities for interaction and longitudinal mentorship with faculty and clinicians in the community, including mentors whose own knowledge or experiences may help mentees navigate issues related to characteristics of diversity during medical school and training;
9. Accreditation standards of training programs that require programs to promote inclusion by requiring demonstrated actions taken to improve diversity;
10. Training for clinicians and healthcare administrators on critical race theory to improve awareness of potential for bias;
11. Decreased weight of Step 1 board examinations and moving toward holistic evaluation in the residency application process;
12. Universal and equal acceptance of COMLEX exams by all US residency programs to decrease the added financial and testing burden placed on underrepresented DO students when they are implicitly expected to take the USMLE series in addition to the COMLEX series;
13. Robust test preparation resources that are integrated into a medical school's curricula to minimize inequality of access to high-quality board prep materials;
14. Change to criteria for honors societies, awards, and opportunities for public speaking and elimination of their use from consideration on applications for training positions, hiring, promotions, and tenure if honors have not been scrutinized for issues of equity; and
15. Increased research in key areas in which the literature related to equity in medicine is lacking. This includes, but is not limited to: impacts of sexual gender minority status on experience of training, access to career advancement, and improvement in clinical care delivered; impacts of improved gender, racial, sexual orientation/gender identity diversity on the quality of care and costs, effective interventions that achieve improved representation, and retention of diversity in the practice of medicine; and reasons for clinicians for reducing work hours and ways to improve full engagement and retention in the profession.

C. That the OMA adopt the Equity Task Force **Recommendations regarding Workforce Culture.**

1. Training for leaders at all levels of organizational structure to be change agents for the development of a positive, inclusive, and respectful workforce culture for all members of a diverse healthcare team, with the goal of moving beyond a focus on reducing legal risk and focus on actively altering culture and climate;
2. Funding for research on medical institutional climates to better understand the problems and needs of medical professionals and academic medical centers in Oregon;
3. Requirements for tracking and reporting progress in equity through measurable data on representation by race, ethnicity, gender, sexual orientation, etc., monitoring retention in the profession and institution; and exploring the experiences people have with discrimination and/or violence at regular intervals;
4. Medical school accreditation tied to evidence of active and meaningful leadership to improve representation of women, racial/ethnic minorities, and LGBTQ+ people in all arenas;
5. Resources to reduce isolation within the profession and to develop systems to elevate voices and concerns of disadvantaged groups to institutional attention, with an eye toward improving culture;
6. Integrated and centralized diversity within the mission of an organization and within the organization's leadership ranks;
7. Transformation by medical institutions of their internal culture through enhancing the visibility of diverse populations in leadership positions and diversifying leadership positions at every institutional level, including, but not limited to, board of directors membership, executive-level organizational leadership, management positions, medical directorships, and tenured faculty roles;
8. Publicly reported data on board of directors and C-suite diversity (including trends in diversity over time) from medical institutions within the state;
9. Promotion and tenure policies to be better adapted to reflect and value the career trajectories and contributions of women and underrepresented groups within academic medicine and other medical organizations;
10. Effective mentorship opportunities, either locally or through national organizations, targeting the specific population/demographic group’s experience of barriers and challenges;
11. Strong, meaningful representation of diversity on panels involved in recruitment and promotion reviews within a medical institution, as well as ensuring diversity among candidates for hire before closing the search to fill a position;
12. Recognition that racism is a *system* that assigns value based on how one looks and internal examination of an organization’s own policies, practices, norms, and values and how they influence decision-making in order to determine how racism is operating within the institution;
13. Access to educational materials and resources to guide the construction of antiracist interventions within medical institutions, including but not limited to identifying who is missing from the decision-making table and what is “on” versus “missing from” the agenda;
14. Close examination of the historical role of sexism/gender bias and racism in an institution or organization to identify how past decision-making and practice may be influencing current policy and climate; the OMA will start by modeling this work internally;
15. Stricter anti-discrimination policies and protections that actively remove barriers to women clinicians and develop an antiracist culture;

16. Adoption of the 2018 NASEM report recommendations for individual, institutional, and legislative changes to reduce workplace discrimination and violence, which include targeted efforts to improve safe and respectful work environments and organizational culture, addressing the most common forms of sexual and gender harassment;
17. Institutional, local, state, and federal legislation that upholds and strengthens the rights and privacy of survivors of sexual harassment and violence and is survivor-centered, including but not limited to changes made to Titles VII or IX;
18. Use and funding of confidential advocates within institutions to support students and professionals who experience harassment and/or violence, with the role of confidential advocates expanded, and appropriately funded, to also address microaggressions and inequities experienced within the organization, with a goal of shifting institutional culture and mitigating current inequities;
19. Zero-tolerance policies for workplace harassment based on race, ethnicity, gender identity, sexual orientation, religion, parenting or caregiving status, disability, or other unique identity held by individuals in the medical workplace;
20. Routine surveying by educational institutions of medical trainees about gender-based violence;
21. Recognition of the value that unique contributions from women clinicians and underrepresented faculty or clinicians offer by modifying promotions processes to positively weight contributions, including but not limited to, underserved patient care advocacy, community service, and research with underserved and minority patients. increased time and commitment to mentoring of women and underrepresented clinicians and students; and time and commitment to diversity work within the organization;
22. Education for academic faculty and organizational leaders about existing literature-documented challenges that women and underrepresented clinicians face and methods to overcome those challenges;
23. Implementation of best practices for collecting data on representation of LGBTQ+ clinicians in the workforce and on the pathway to the workforce, including applicants to medical school, residency, and fellowship training;
24. Efforts and initiatives directed at more broadly Implementing early-career debt relief;
25. Performance evaluation criteria and advancement criteria that are explicit and transparent, including the standards for advancement when a clinician works part-time or has a leave of absence for caregiving responsibilities; to be reviewed annually with employees to identify areas of difficulty and ensure success;
26. Targets for hiring, retention, and advancement of women and underrepresented members of clinical and academic teams and that leadership team reviews, and program accreditation be tied to success in these arenas;
27. Opportunities for leadership training and mentoring in medical organizations, academic institutions, and practices, with a focus on women and other underrepresented clinicians;
28. Family-friendly policies and adjustments to the promotion cycle within organizations that allow for career customization and individualized career plans which span a faculty member’s career, with options to flex up or down in research, patient care, administration, and teaching;
29. Increased availability of pilot funds from academic and governmental institutions to lower barriers for research and systematically monitor startup packages for research and academic work to ensure resources are equitably distributed, regardless of demographic differences; and
30. Training for decision-makers of hiring, promotions, and leadership to recognize their own biases and on the organizational imperatives around improving diversity.

D. That the OMA adopt the Equity Task Force Task Force **Recommendation regarding Caregiving Responsibilities.**

1. Flexible course schedules within medical schools that allow for caregiving for family members, with efforts made to ensure timely graduation and progress;
2. Residency application process and cycles that increase options for trainees who seek to care for family members, such as a second application cycle to minimize unused time off;
3. Family leave policies that are opt-out, as opposed to opt-in, with reasonable wage replacement rates;
4. Gender-neutral parental and family leave that would ensure protection for LGBTQ+ families that otherwise face unequal social and economic treatment;
5. High quality publicly and institutionally supported childcare, including backup care for sick children;
6. Accessible lactation resources in workplace and academic settings and standardized policies regarding scheduling accommodations to support breastfeeding;
7. Opportunities for flexible work schedules;
8. Resources to ensure the provision of childcare in emergency and on-call situations;
9. Increased resources for in-home care for the elderly and reduced-cost high quality options for institutional care; and
10. Increased research on care for older adults by “sandwiched” families.

E. That the OMA adopt the Equity Task Force **Recommendations regarding Patient Relationships.**

1. Increased research on how to improve identity-conscious care;
2. Improved education for trainees and continuing education for practicing clinicians that addresses not just issues of cultural difference, but systemic racism, sexism, homophobia, and transphobia, and provides tools to examine these issues;
3. Self-assessment of institutional bias by healthcare organizations while creating a robust support system for clinicians and other healthcare members;
4. Nuanced approaches to reimbursement to account for differences in patient utilization and care needs;
5. Discrimination reporting systems for both clinicians and patients within healthcare organizations;
6. Funding to increase access to healthcare resources and clinician training in rural settings:
7. Resources for clinicians to adequately assess their appropriate amount of workload in their patient panels and support these findings with appropriate panel assignment;
8. Policies within healthcare organizations that explicitly address patient bias, with a clear mechanism for reporting incidents of patient bias and procedures to inform decisions about future care of the patient and support of the medical staff; and
9. Standardized responses by medical groups and healthcare institutions to be directed to patients who demand different clinicians due to patient bias against clinicians.

F. That the OMA adopt the Equity Task Force **Recommendations regarding Pay.**

1. Routine collection of data on pay and total compensation by all large medical groups, academic institutions, and coalitions of smaller groups, carried out with attention to

demographic factors and any factors that may account for differences in compensation, with special attention to groups that have not yet been well evaluated;
2. Consideration for protecting privacy and confidentiality in developing methods of data collection and sharing;
3. Governmental support and funding for data collection and pay disparity research;
4. Standardization within medical institutions and groups of starting position salary based on specialty, rank, and region;
5. Omission of questions about previous compensation during the application, interview, and hiring process;
6. Routine audits of total compensation (clinical and non-clinical) for large clinician practices performed by outside consultants, with results of the analysis shared with a diverse supervisory and accountable leadership group or with the division director;
7. Incorporation of equity metrics into quality targets or annual evaluations of organizational leaders;
8. Transparency on how initial and subsequent salary is determined and data on current compensation levels (including information on rank, years of employment, gender, race, and other pertinent demographic data);
9. Adjustments in salaries made if unexplained differences are identified;
10. Compensation based on a broad range of factors that value the overall experience of the clinician beyond FTE and productivity;
11. Implementation of compensation models that reduce inequities, such as: salary-only structured compensation models incorporating national benchmarks and clear standardized pay steps and increments, structured compensation models based on rank and time-in-rank in a given subspecialty, value-based compensation systems, and development of an “academic RVU” measure that can also be used to determine compensation;
12. Public access to national salary data such as the AAMC salary report;
13. Evaluations of compensation that include a comprehensive view of compensation including: retirement benefits, disability/malpractice insurance, health benefits, access to pay for performance or bonuses; research support; division of work between clinical, teaching, committee, and research responsibilities; access to leadership opportunities; and factors impacting clinical workload for individual clinicians;
14. Avoidance of patient satisfaction metrics such as Press Ganey or HCAHPS as factors in deciding compensation, bonus, and advancement unless there are robust data demonstrating that patient bias has no statistical effect;
15. Consideration for differences in risk levels of patient panels when using quality of care measures to determine compensation, to avoid penalizing clinicians for caring for more complex groups of patients;
16. Precise promotion guidelines (e.g. number of papers, size of grants) for academic positions and availability of an experienced senior faculty member who can counsel faculty on readiness for promotion;
17. Consideration of valuation of citizenship work (e.g. committee, mentoring, service work); rewarding activities central to medicine like teaching and committee membership;
18. Specific criteria for earning add-on bonuses available and achievable by all the members of the group, with routine updates on progress toward the goal provided by leadership;
19. Performance reviews coupled to routine assessments for compensation adjustment;
20. Human Resources involvement in countering forces pushing toward compensation inequities, by evaluating job offers to ensure they’re based on the value the position brings to the organization and not on what the candidate earned previously, participating in routine pay equity analyses to determine if pay is based on relevant variables like

market value, experience, last three performance ratings, utilizing peer group settings to discuss and defend the distribution of raises; and monitoring hiring, promotions, and raises to ensure they are bias free and explicit regarding who is responsible for equitable pay;
21. Term limits for leadership positions;
22. Standardization and transparency related to how decisions about part-time status and family/medical leave impact advancement, bonuses, and expectations about productivity in a given period of time;
23. Research to identify the policies, procedures, leadership, and/or culture that promote equity in some specialties in order to determine best practices and target the effective remedies to disparities in all specialties; and
24. Federal and state legislation to address wage gaps such as the Paycheck Fairness Act.

See also Appendix M (February 2021)

PROTECTIONS FOR LGBTQ+ HEALTH PROFESSIONALS

1. The OMA adopts the following policy statement and places in *Where We Stand*:

Protections for LGBTQ+ Health Professionals

OMA recognizes the educational and professional challenges unique to LGBTQ+ health professional students and professionals as well as professionals who provide gender-affirming and LGBTQ+-related healthcare, and OMA supports policy that promotes protections for LGBTQ+ health professionals.

2. That the OMA adopt the following recommendations regarding Protections for LGBTQ+ Health Professionals into *Where We Stand*:

GLMA: Health Professional Advancing LGBTQ+ Equality Adapted Principles

Number 1 Health care organizations and providers should interact, conduct business, negotiate employment and personnel matters, and provide healthcare with current and potential employees, members, constituents, and patients without bias or discrimination on the basis of sex, sexual orientation, gender identity, or gender expression, and should include sexual orientation, gender identity, and gender expression in their nondiscrimination policies.

Number 2 Health professions' education and training programs should not discriminate based on race, ethnicity, sex, gender, age, sexual orientation, religion, national origin, gender identity, gender expression, veteran status or disability; and should support equitable recruitment and inclusion of health professions students and trainees from diverse and under-represented backgrounds.

Number 3 Discrimination should not be permitted in hiring, employment, employment practices, promotion, recruitment, and admissions-related decisions on the basis of sex, sexual orientation, gender identity, and gender expression.

Number 4 Discrimination of LGBTQ+/Sex, sexual, and gender minority (SGM) people should not be permitted in employment and education and the association should explore the inclusion of transgender people as a protected group.

Number 5 Reproductive health rights of all people, regardless of sex, sexual orientation, and gender identity, who are capable of bearing children should be protected to allow unencumbered access to the full range of reproductive services as a matter of public health, health equity, and liberty. Further, health care practitioners must be able to communicate all relevant medical information to those seeking their care as a matter of evidence-based, best health care practices.

Number 6 There should be broad advocacy that opposes governmental attempts, at all jurisdictional levels, seeking to intrude upon the patient-practitioner relationship in determining medical necessity and the ability to discuss evidence-based, health-promoting options including pregnancy termination.

AMA Supporting LGBTQ+ Individuals and Health Professionals Adapted Principles

Number 7 Support the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender and non-binary individuals according to one's gender identity.

Number 8 Support the dignity of the individual, human rights and particularly the right to health, defined as the highest attainable state of health; oppose discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age; and recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States.

Number 9 Physician practices, health professions schools, hospitals, and clinics should be encouraged to broaden nondiscrimination statements made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity."

Number 10 Workplaces should be safe environments and include support for healthcare professionals providing evidence-based gender-affirming care against threats, intimidation, and acts of violence.

OMA Protection From Harassment and Harm When Delivering Care Principles

Number 11 Support protections for healthcare professionals providing gender-affirming care and/or LGBTQ+-related healthcare.

Number 12 Not tolerate violence, acts of force, threats, intimidation, harassment, or property damage related to preventing access to gender-affirming and/or LGBTQ+-related healthcare.

Number 13 Support penalties for violence, acts of force, threats, intimidation, property damage, harassment, or physically preventing access to gender-affirming and/or LGBTQ+-related healthcare.

Number 14 Support the development of protocols and the creation of resources to support health professionals facing violence, acts of force, threats, intimidation, harassment, property damage for the provision of gender-affirming and/or LGBTQ+-related healthcare.

Number 15 Support protection of the physical space around health facilities providing gender-affirming and/or LGBTQ+-related healthcare.

Number 16 Support protections related to the disclosure of patient medical information and data from investigators in other states, including the records of individuals who travel from a state where gender-affirming and/or LGBTQ+-related healthcare is restricted.

See Appendix T
(June 2023)

TRAINING HEALTH PROFESSIONALS ON LGBTQ+ TOPICS

1. The OMA adopts the following policy statement and places in *Where We Stand*:

Training Health Professionals on LGBTQ+ Topics:

OMA recognizes the educational and professional need to train health professionals on LGBTQ+ topics, and OMA supports policy that improves and ensures training on LGBTQ+ topics.

2. The OMA adopts the following recommendations regarding Training Health Professionals on LGBTQ+ topics and places in *Where We Stand*.

GLMA*: Advancing LGBTQ+ Equality related to Training, Education, and Competencies for Health Professionals on LGBTQ+ Topics

Number 1: Health issues affecting LGBTQ+ persons should be taught in an affirming and culturally competent manner at all levels of health professional education and training.

Number 2: Health education regulatory and accrediting bodies should develop, monitor, and support curricula that aims to improve cultural competence, cultural humility, and clinical knowledge base around issues of sex, gender identity, sexual orientation, and population specific health issues affecting LGBTQ+ persons.

Number 3: Private, state, and federal health insurance organizations should identify healthcare clinicians with competency in LGBTQ+ health care and assure

that clinicians with these skills are included in the practitioner panels available to patients.

Number 4: Health professional education and training programs should not discriminate based on any identity, background, or status.

Number 5: Research and education about factors that influence the health of LGBTQ+ youth should be encouraged.

Number 6: Development of culturally competent education for healthcare professionals and development of best practice guidelines regarding treatment of individuals with differences of sex development should be encouraged.

AMA Policy Supporting Training, Education and Competencies for Health Professionals on LGBTQ+ Topics

Number 7: Health professionals' nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to create a patient-centered care environment for LGBTQ+ people.

Number 8: Education of new and current health professionals with up-to-date information on LGBTQ+ health should be added to continuing education. Highlight the need to obtain relevant gender and sexuality information from the patient.

Number 9: Health professionals should recognize the different needs of LGBTQ+ patients and should seek out experts in the needs of these populations when necessary.

Number 10: OMA opposes "reparative" or "conversion" therapy for sexual orientation or gender identity.

Number 11: OMA encourages collaboration with partner organizations to educate physicians and health professionals regarding:

(i) the need for sex, sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions;
(ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men;
(iii) the appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and
(iv) the need for understanding that individuals who identify as a sex, sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual individuals) experience intimate partner violence, and how sex, sexual, and gender minorities presenting with intimate partner violence differ from their cisgender, heterosexual peers.

Number 12: OMA will work to increase physician and health professional competency on LGBTQ+ health issues.

Number 13: OMA will explore opportunities to collaborate with other organizations, focusing on issues of mutual concern to provide the most comprehensive and up-to-date education and information for LGBTQ+ people.

OMA Recommendations on Training, Education and Competencies for Health Professionals on LGBTQ+ Topics

Number 14: Urges health care organizations, health professionals and educators to use gender inclusive language; revise policies, procedures, and written materials to incorporate gender inclusive language, and train health professionals on the use of gender inclusive language in verbal and written communication.

Number 15: Calls for training for health professionals and trainees on sex, gender identity and expression, and sexual orientation, to educate patients on these topics when appropriate; urges that health professionals seek ongoing training to provide up-to-date educational resources on these topics.

Number 16: Advises healthcare organizations, health professionals, and educators to be informed about current language pertaining to LGBTQ+ topics, including pronouns, sex, sexual orientation, asexuality, gender, gender identity, gender expression, in an ongoing way.

Number 17: Recommends healthcare organizations and health professionals practice culturally competent and gender-inclusive charting, specifically regarding using the patient's correct name, gender, and pronouns. Recommends that healthcare professionals are educated on the need to ask about who the patient identifies as family and how to advise patients on their rights when the patient's chosen family is not their legal family (e.g., medical and legal paperwork for surrogates or proxies).

Culturally competent and gender-inclusive charting includes:
(i). Conversations with patients to understand if they are "out" to their family or other health professionals
(ii) What they would like or not like to be shared, so that their information is protected when appropriate

Number 18: Urges healthcare organizations, health professionals, and educators to receive education about health disparities experienced by LGBTQ+ patients, including barriers to accessing health care (i.e.., poverty, social isolation, depression, long term/palliative care facilities), susceptibility to diseases (especially sexually transmitted infections (STI) and chronic diseases), mental health, and medical mistrust.

Number 19: Calls for healthcare organizations, health professionals, and educators to prevent discrimination, neglect, harm, and abuse of LGBTQ+ persons by the medical field.

Number 20: Recommends healthcare organizations, health professionals, and educators understand and unlearn explicit and implicit biases against LGBTQ+ persons.

Number 21: Urges healthcare organizations, health professionals, and educators to reduce the stigma around STIs commonly associated with LGBTQ+ persons.

See Appendix V
(September 2023)

PROTECTION OF HEALTHCARE AND HUMANITARIAN AID PERSONNEL IN CONFLICT ZONES

Number 1 Condemnation

That the Oregon Medical Association (OMA) condemns all forms of violence, forced displacement, and interference—by any party and in any location—against healthcare personnel, humanitarian aid workers, and healthcare institutions. The OMA calls for a ban on the targeting, detention, or attack of healthcare workers and institutions, and demands the immediate release of any healthcare or humanitarian personnel held captive. The OMA opposes the use of force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, whether domestically or internationally.

Number 2 Multi-Level Advocacy

That the OMA will advocate at all appropriate levels—including legislative, judicial, regulatory, and public policy arenas, and to support policies ensuring unrestricted, equitable, and safe access to humanitarian aid and medical supplies for all critically affected populations

Number 3 Support for International Recognition and Oversight

That the OMA urges the United States Congress to support United Nations efforts to condemn the practice of using force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, and to establish a mechanism to provide oversight and protection of medical response in humanitarian crises. This includes supporting mechanisms for documentation of violations and enforcing accountability (PHR, 2024; Washington Centre, 2024).

Number 4 Advocacy within Organized Medicine

That the OMA will direct the OMA delegation to the AMA requesting that the AMA amend H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict as described below with the addition of **c-e**.

a) Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.
b) Our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.
c) **Our AMA condemns the use of all forms of violence, forced displacement, and obstruction of any aid and healthcare in any location against healthcare personnel, humanitarian aid workers, and healthcare institutions.**
d) **Our AMA advocates for an absolute ban on targeting, detention, or attack of healthcare workers, humanitarian personnel, and their institutions, and demands the immediate release of any healthcare or humanitarian personnel held captive.**
e) **Our AMA actively opposes the use of force or violent means to prevent, restrict, or interfere with the delivery of medical supplies, healthcare, or humanitarian aid, whether domestically or internationally.**

See Appendix AE
(February 2026)

WHERE WE STAND - APPENDIX

APPENDIX A

APPENDIX A: CONTROLLED SUBSTANCES: DEA GUIDELINES

Purpose: The purpose of these guidelines is to establish an acceptable professional response to the demands of the Controlled Substances Act. The guidelines, based on those proposed by the Drug Enforcement Administration's Practitioner Committee, provide a commonsense approach to encourage voluntary compliance by the prescribing professions.

General Statement: The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way to supersede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective professional organizations. Accountability is the responsibility of each discipline.

General Guidelines:

- Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing when they are clinically indicated.
- Prescribing controlled substances for legitimate medical use requires special caution because of their potential for abuse and dependence.
- Physicians should exercise good judgment in administering and prescribing controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.
- Physicians should guard against contributing to drug abuse through injudicious prescribing practices, or by acquiescence to unwarranted demands by some patients.
- Each prescriber should examine his/her prescribing practices to insure that all prescriptions for controlled substances are being written with caution.
- Prescribers should make a special effort to ensure that multiple prescription orders are not being obtained by the patient from different practices/prescribers.

Legal Requirements:

- The prescriber is granted through legal authority the right to prescribe medications that are necessary for the treatment of his/her patients. Prescribing is governed by laws and regulations, which set forth minimum standards and requirements.
- Separate laws relating to the distribution of controlled substances have been enacted in most states. Oregon law is virtually identical to the Federal Controlled Substances Act. Passed by Congress in 1971, the law is administered by the State Board of Pharmacy. Close cooperation between law enforcement and medicine will insure that legitimate drugs remain in legitimate channels.

- The legal requirements that apply to writing prescriptions for controlled substances include the following and are made a part of these guidelines for informational purposes:
  - The prescription order must be signed by the prescriber when it is written.
  - The prescriber's name, address and DEA registration number must be included on the form, as well as the full name and address of the patient.

- A written prescription is required for drugs in Schedule II. Only in emergency conditions can oral orders for Schedule II drugs be accepted by a dispenser. Such oral orders must be followed by a written prescription within 72 hours.
- The renewing of Schedule II prescriptions is prohibited.

- Prescription orders for Schedules III, IV and V may be issued either orally or in writing and may be renewed if so authorized on the prescription order. The prescription order is valid for six months from the date of issue, during which time it may be refilled up to five times.

APPENDIX B

APPENDIX B: THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

(Adapted from the policy of the Federation of State Medical Board of the United States, Inc., May 1998 and editorially modified to be applicable to a state medical association as opposed to a state licensing board. Adopted by the Oregon Medical Association House of Delegates, April 25, 1999)

Section I.- Preamble

The Oregon Medical Association (OMA) recognizes that principles of quality medical practice dictate that the people of the State of Oregon have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. OMA encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify OMA's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty as to the applicable standard of practice, and to encourage better pain management.

OMA recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the U.S. Agency for Health Care and Research Clinical Practice Guidelines for a sound approach to the management of acute[1] and cancer-related pain[2].

The medical management of pain should be based on current knowledge and research and includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses

should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Oregon Board of Medical Examiners is obligated under the laws of the State of Oregon to protect public health and safety. OMA recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board of Medical Examiners or other state regulatory or enforcement agency for prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain should be evaluated on an individual basis. OMA believes action against a physician is not necessarily justified for failing to adhere strictly to the provisions of these guidelines if good cause is shown for such deviation. The physician's conduct should be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medical and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's needs – including any improvement in functioning – and recognizing that some types of pain cannot be completely relieved.

1. Acute Pain Management Guideline Panel. **[**Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline: AHCPR Publication No. 92-0032]. Rockville, MD, Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service, February 1994.

2. Jaycox A, Carr, DB, Payne R. et.al.[Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592.] Rockville, MD. Agency for Health Care Policy and Research, U.S. Department of Health and Human Resources, Public Health Service, March, 1994 diagnosis, the patient's needs - including any improvement in functioning - and recognizing that some types of pain cannot be completely relieved.

The following guidelines are not intended to define complete or best practices, but rather to communicate what OMA considers to be within the boundaries of professional practice.

Section II – Guidelines

1. **Evaluation of the Patient** - A complete medical history and physical examination must be conducted and documented in the medical record. The medical record

should document the nature and intensity of the pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indicators for the use of a controlled substance.

2. **Treatment Plan** - The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. **Informed Consent and Agreement for Treatment** - The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including: urine/serum medication levels screening when requested; number and frequency of prescription refills; and reasons for which drug therapy may be discontinued (i.e. violation of the agreement).

4. **Periodic Review** - At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living, and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. **Consultation** - The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse and diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. **Medical Records** - The physician should keep accurate and complete records to include: the medical history and physical examination; diagnostic therapeutic, and laboratory results; evaluations and consultations; treatment objectives; discussion of risks and benefits; treatments; medications (including date, type, dosage, and quantity prescribed); instructions and agreements; and periodic reviews. Records should

remain current and be maintained in an accessible manner and readily available for review.

7. **Compliance with Controlled Substance Laws and Regulations** - To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state laws and regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and to the most recent edition of OMA Medical-Legal Handbook for specific rules governing controlled substances as well as applicable state law and regulation.

Section III – Definitions

1. **Acute Pain:** Acute pain is the normal, predicted physiological response to adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

2. **Addiction:** Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as “drug dependence” and “psychological dependence.” Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

3. **Analgesic Tolerance:** Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

4. **Chronic Pain:** A pain state, which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

5. **Pain:** An unpleasant sensory and emotional experience associated with actual or potential tissues or described in terms of such damage.

6. **Physical Dependence:** Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

7. **Pseudoaddiction:** A pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

8. **Substance Abuse:** Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than for which it is prescribed.

9. **Tolerance:** Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPENDIX C

APPENDIX C: PAYMENT REFORM PRINCIPLES

Appropriate patient and provider roles in a reformed system:

1. Physicians, other health care providers and informed patients must be the core decision makers for each patient's individual health;
2. The planning and implementation of payment reform models must include broad participation by physician groups and should be conducted in a transparent manner;
3. Physicians must have a leadership role and decision making authority over the distribution of shared savings and bonus payments;
4. Policies should create incentives to prioritize healthy lifestyles and emphasize personal responsibility in addition to improving medical quality and outcomes.
5. All payment reform models must be designed to mitigate the practice of defensive medicine.

Access to the spectrum of care:

6. Payment reform models must recognize and support the essential contributions primary and specialist physicians make to excellent care;
7. Stakeholders should be mindful to determine which diagnoses or treatments may be increasing costs inefficiently based on best practices and address those specifically instead of simply decreasing provider payments or patient benefits.
8. The OMA confirms support of comparative effectiveness research (CER) as a means to guide physicians in the best care options for their patients. It also supports that physician discretion in the treatment of individual patients remains central to the practice of medicine.

Implementing reform:

9. Any new initiatives should provide adequate timeframes and resources for implementation;
10. Legal restrictions to some payment reform models will need to be examined; necessary legal changes should be pursued, such as changes to antitrust restrictions within cost sharing arrangements;
11. Recognizing that multiple pathways exist to meaningful reform, and that hybrid approaches may help to minimize unintended consequences, demonstration projects that allow for innovation and for physicians to effect change within their local communities should be encouraged;
12. Pilot payment reform projects must be evaluated carefully to determine that they are efficient and effective in delivering high quality care before broader implementation;

Stipulations for payment reform modeling:

13. Discussions of bundled or global payments should reflect a fair representation of all stakeholders in the distribution of payments; no stakeholder should have an advantage over another;

14. New payment models should not be based on Medicare's fee-for-service payment rates and methods because of inherent flaws with its formulas, such as the Sustainable Growth Rate and geographic payment disparities;
15. Payment reform models must consider smaller and solo practice clinics and should be flexible in design to allow these practices to meet the needs of their communities;
16. Quality measures for payment reform models within different payer systems, such as pay for performance, should be based on specialty-specific, evidence-based standards where applicable; such evidence should also be used to guide clinical decision making;
17. Reform models must adequately compensate providers for team-based care and coordination, including management, consultation with other health care providers and non face-to-face communication with patients.

APPENDIX D

APPENDIX D: ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE PRINCIPLES

Regarding Electronic Medical Record Adoption:

1. Support legislation that provides incentives for adoption and implementation of Health Information Technology (HIT).
2. Support policies, education and applicable regulations that mitigate the disruption to practice inherent in major changes of this kind.
3. Support requirements on vendors to ensure interoperability, as it is essential to allow movement of data through secure HIE structures.
4. Support Electronic Health Record (EHR) systems that allow appropriate participation by all team members in use of the EHR in the course of care of the patient, including for example, Computerized Physician Order Entry, documentation, etc.
5. Support use of decision support modules contained in EHR that increase patient safety and decrease errors of omission at the point of care.
6. OMA will, where possible, provide its members with resources to help them in vendor selection for HIT projects, with the emphasis on sources that will help them improve quality, ensure interoperability with existing clinical systems, and enhance efficiency and viability of their practices.
7. OMA will also work with knowledgeable vendor neutral sources to create educational programming and information sources that will prepare physicians and practice staff for the financial benefits and risks associated with adoption of HIT.
8. OMA will provide its members with up to date information about the development and implementation of HIT policy changes at the state and national levels.
9. OMA will advocate with policymakers to present as full a picture as possible of the impacts these changes will have on individual physicians.

Regarding Health Information Exchange:

1. Patient safety, privacy and quality of care are the guiding principles of all Health Information Exchange (HIE) efforts; cost reduction and efficiency are expected byproducts but not the primary aim.
2. Patient privacy protections that traditionally exist in the patient-physician relationship continue to apply where health information technology is utilized.

3. The OMA supports a system in which a patient is given the opportunity to opt-out of participation in health information exchange; if the patient does not opt-out, their information will be accessible to the health information exchange (with the exception of specially protected records as defined by state and federal law).
4. Open standards for the interoperable electronic transmission of clinical data should be compatible with national and regional standards.
5. The OMA supports a model for creating a Health Information Exchange entity that draws its financial sustainability from a reasonable fee, scaled to user size and type, which incorporates shared support from all those who benefit from it; said fees must only be collected for ongoing maintenance of the exchange, rather than start-up costs.

APPENDIX E

APPENDIX E: OMA ANTITRUST GUIDELINES

I. Statement of Policy

It is the policy of the Oregon Medical Association to comply with all laws applicable to association activities. The OMA emphasizes its ongoing commitment to full compliance with federal and state antitrust laws. This statement is distributed to all officers, trustees, committee chairmen, committee members and staff as a reminder of the commitment and as a general guide for activities and meetings.

II. Responsibility of Antitrust Compliance

The OMA's programs have been carefully designed and reviewed to ensure conformity with antitrust standards. An equivalent responsibility for antitrust compliance rests with members. The Association depends on good judgment to avoid all discussions and activities which may involve improper subject matter or improper procedures or even an appearance of improper activity. Association staff members work conscientiously to avoid subject matter discussion which may have unintended implications, and OMA counsel routinely provides guidance with regard to these matters. It is important to realize, however, that the competitive significance of a particular conduct or communication probably is most evident to those who are directly involved in medicine. For this reason members have an important and individual responsibility to further antitrust compliance in Association activities. Moreover, no officer, trustee, or any other OMA member, whether acting in his or her individual capacity or as a committee or in any other way, is authorized to propose or carry out on behalf of the Oregon Medical Association any program, agreement, or other activity in violation of state or federal antitrust laws.

III. Antitrust Statues and Legal Background

The federal antitrust laws consist of four principal statutes: the Sherman Act, the Clayton Act, the Robinson-Patman Act, and the Federal Trade Commission Act. The most important statutes relating to the activities of a professional association or society are the Sherman Act and the Federal Trade Commission Act.

The Sherman Act was passed in 1890 and contains two principal prohibitions. Section 1 prohibits any agreements between two or more persons or legal entities which is deemed to restrain trade. Section 2 forbids monopolization of conspiracies to monopolize.

The Supreme Court has ruled that not every contract or combination in restraint of trade is a violation. Only those which unreasonably restrain trade are unlawful.

Certain types of conduct have been held to be so inherently or nakedly anticompetitive that such activities are "per se" violations of the law, and further proof is unnecessary. Such violations include:

1. Price fixing agreements
2. Agreements to refuse to deal with certain third parties (boycotts)
3. Agreements to allocate markets or to limit production
4. Tie-in sales, which require the customer to by an unwanted product or service in order to obtain the desired item.

Since a professional association, by its nature, brings competitors together to carry out its programs, the potential for collusion exists. Because of this potential, enforcement agencies are watching professional organizations, especially in the medical profession, very carefully.

For antitrust purposes, the term "agreement" is very broadly applied. It includes oral or written, formal or informal, express or implied agreements. There are cases where an unlawful agreement has been inferred from circumstantial evidence, such as the words and conduct of the parties and their course of dealing.

IV. Enforcement and Penalties

The consequences of an antitrust violation by any individual or business entity are severe. All federal statutes may be enforced by prospective orders and injunctions obtained by the government to compel compliance in the future. In addition, criminal penalties and private treble damage suits are likely.

Civil suits may also be brought by any person injured in his/her business or property by violations of the Sherman or Clayton Acts. Under Section 4 of the Clayton Act, any plaintiff establishing actual damages automatically receives judgment for three times the damages sustained, plus an award against the defendants for the amount of the plaintiff's attorney fees. See for example, Patrick v. Burget, et al.. 100 L Ed. 2nd 83, 108 S Ct. 1658, (1988), U.S. reh. den. 108 S. Ct. 2921.

V. Antitrust Problem Areas of Association Activity

The areas of antitrust law which seems to arise most frequently in connection with the activities of a professional association are:

1. Price for free fixing, keeping or publishing fee schedules
2. Standardization or stabilization of fees or charges
3. Agreements to divide patients or market areas
4. Membership restrictions which seek solely to exclude economic competitors
5. Certain peer review activities

VI. Avoidance of Antitrust Problems

In the absence of specific legal advice on matter, at or during Association activities, please follow the guidelines set forth below.

A. Topics of Discussion to be avoided by members during Association activities:

1. Do not discuss one's own or other physicians' current or future fees. This does not prohibit private discussion among partners or shareholders at meeting of one's own clinic members.
2. Do not discuss possible increases or decreases in fees. (note exception regarding partners, etc. in paragraph 1 above).
3. Do not take part in any discussion of what should be considered a fair fee for procedure (note exception in paragraph 1 above).
4. Do not make any public statements about one's own fees or the fees of competitors, or about any other matters which could affect fees.
5. Do not discuss with other physicians what one's plans are in a particular geographic area or market, or with particular patients or with third party payers.
6. Do not express any intent to refuse to deal with an HMO, a PPO, or any other third party payer, or with any group or class of patients.
7. Do not encourage any other physicians to refuse to deal.
8. Do not disclose any other person, at meetings or otherwise information which may be sensitive competitively.
9. If one is present when any discussion as mentioned above takes place, and is unable to prevent such discussion, one should remove oneself from the meeting.
10. Decline service on a peer review panel when a direct competitor is being reviewed.

B. Meeting Procedures:
To avoid even the appearance of questionable activity, as well as to guard against any inadvertent illegal conduct, all Association meetings, including committees, should be conducted in accordance with the following procedures:
1. In advance of every meeting, a notice of the meeting should be sent to each member of the group; and the agenda should be specific. Broad topics, such as "Marketing Practices" which might look suspicious from an antitrust standpoint should be avoided.
2. The discussion at the meeting should be limited to agenda items. Topics such as "old business" and "new business" may be discussed; however, caution should be exercised in bringing up non-agenda topics which could be construed as antitrust-sensitive.
3. If a member brings up a subject of doubtful legality, that person should be advised the subject is not a proper one for discussion. This would primarily be the responsibility of legal counsel for the Association. If a member has reservations concerning remarks or nature of discussion at an Association meeting, those reservations should be expressed and, if the discussion is not terminated or satisfactorily resolved, that member should leave the meeting.
4. Accurate minutes only of the actions of meetings should be prepared and if reasonably possible, sent to the chairman and other group members before the next meeting. Periodic review of the minutes should be conducted by legal counsel.
5. Secret or "rump sessions" should be strictly avoided. It is desirable if possible that a staff member attend all meetings.
6. No recommendations or actions should be taken with regard to antitrust, sensitive subjects, without the advice of the Association's legal counsel.

VII. Conclusion

Compliance with these guidelines is intended not only to avoid antitrust violations, but also any behavior which could be so constructed. However, it should be understood that the antitrust laws are complex and far-reaching, and this statement is not a complete summary of the law. It is intended only to highlight an emphasize certain basic precautions designed to avoid antitrust problems. Members must therefore seek the guidance of either Association staff, its legal counsel, or one's own attorney if antitrust questions arise. For further information concerning OMA's antitrust compliance procedures, please contact the Association staff.

APPENDIX F

APPENDIX F: STATEMENT OF PRINCIPLES GOVERNING CERTAIN LAWYER-PHYSICIAN RELATIONSHIPS

Physicians and lawyers are each members of a profession dedicated to furnishing professional skills and service to the public. Certain problems have arisen in each profession in connection with the other than might result in detriment to the patients or clients of each profession, to the professions themselves, and to the public as a whole.

In an endeavor to create a better understanding and a closer relationship and unity between the legal and medical professions; that each may better serve the other and the public, and in order to provide a solution to certain common problems, the following Rules of Conduct have been adopted by the Oregon State Bar and the Oregon Medical Association, each in convention assembled:

1. Committee Organization – Each organization shall appoint three or more members from its profession who shall serve on a committee, one to serve for a term of one year, another for a term of two years, and a third for a term of three years, and thereafter members shall be appointed for a term of not less than three years; and said six or more individuals shall constitute the Joint Medical-Legal Committee. Such committee shall:

a. Promulgate such suggestions as may be necessary to carry into effect the Rules of Conduct hereby adopted.
b. Jointly attempt to mediate and arbitrate, in the first instance, any disputes arising between individual physicians and attorneys or between the two professions.
c. Report annually to each of said organizations the work of the committee during the year and make such recommendations as the committee deems desirable.

2. Cooperation – Members of the legal profession shall not give medical advice to their clients and members of the medical profession shall not give legal advice to their patients.

3. Medical Reports –

a. No attorney should request and no physician should furnish any information concerning the history, physical condition, diagnosis or prognosis of a patient except with the written consent of the patient or in conformity with the rules of the Workers' Compensation Department of the State of Oregon, Oregon Rules of Civil Procedure, or other applicable legal authority.
b. In the absence of contractual provisions to the contrary, the patient, or his attorney as his duly authorized agent, shall be entitled, upon written request, to a prompt report from the attending or treating physician concerning history, findings, treatment, diagnosis and prognosis, whether or not a governmental agency, insurance carrier, or third party is responsible for the patient's care.
c. It is the obligation of the attorney to designate the type of report he requires.

d. If a medical examination is requested or arranged by a party adverse to the individual being examined, or by a prospective employer as a pre-employment medical examination, the report of such examination shall be made directly to the person arranging for such examinations and to no other individual or agency.

4. Pre-trial Discussions – Subject to the physician-patient privilege, pre-trial discussions between physicians and attorneys of the medical questions involved shall be encouraged.

5. Testimony – Treating and consulting physicians shall be available for testimony in court regarding the patient's condition, treatment, diagnosis, prognosis and other matters upon request of the patient or his attorney after reasonable notice is given.

6. Fees and Charges –

a. The physician shall be entitled to charge a reasonable fee for medical reports, conferences with attorneys, and medical testimony.
b. Charges for mechanical copying of previously prepared reports shall be billed on the basis of clerical time, effort and materials involved on the part of the physician's staff.
c. Fees for medical testimony shall not be contingent upon outcome of the litigation.
d. If scheduled medical testimony is cancelled, the physician shall be entitled to charge depending on the time of notice and nature of practice.
e. An attorney shall not charge a fee to the physician for obtaining payment of a bill for medical services in personal injury litigation.
f. The attorney has an obligation to use every appropriate means to see that medical fees are paid by the client when money is disbursed either after settlement or after a judgment has been obtained.
g. Whenever medical reports, conferences, or medical testimony are requested by an attorney, it will be conclusively presumed that the attorney has made arrangements with the client for payment and all reasonable charges shall be paid promptly by the attorney.
h. If a proposed settlement or actual recovery is insufficient to cover all expenses and the attorney, on behalf of the client-patient, wishes to propose a proportionate reduction of the medical or hospital bill or both, it is suggested that the attorney should present in writing the proposed or actual gross receipt of funds and the proposed plan of settlement, including the normal or contractual attorney fee and the actual amount the attorney proposes to charge in such instance.

7. Records Belonging to Physician – All original records of attending physicians made in connection with treatment and care of the patient, including radiographs and reports of diagnostic and therapeutic procedures, are the property of the physician.

8. Reasonable Inquiry – An attorney shall make reasonable inquiry to determine if there has been a doctor-patient relationship before issuing a subpoena or demanding a report from a doctor.

(As approved and adopted by the Oregon State Bar and the Oregon Medical Association and revised in November, 1984.)

APPENDIX G

APPENDIX G: GUIDELINES FOR THE WITHDRAWAL OF LIFE-SUSTAINING PROCEDURES WITHOUT A DIRECTIVE TO PHYSICIANS (LIVING WILL)

The "Right to Die" Law is optional and does not require a physician to discontinue treatment.

There is a question whether the law applies to individuals who are under the age of 18. It is recommended by legal counsel that physicians treating patents under 18 should seek legal advice before withdrawal of life-sustaining procedures for those patients who otherwise meet the statutory qualifications set forth below.

Amendments to "Right to Die" Law

The new statute is intended to apply to a patient who is in a hospital or long term care facility (which includes a skilled nursing facility or an intermediate care facility) and who:

1. Has had life-sustaining procedures instituted; and
2. Has a terminal condition; and
3. No reasonable possibility of returning to a cognitive sapient state; and
4. Is comatose; and
5. Has not executed a "Directive to Physicians."

"Terminal condition" means an incurable condition caused by injury, disease or illness, which, regardless, of the application of life-sustaining procedures would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of patient.

"Directive to Physicians" is a specific statutory form directing the withholding or withdrawal of life-sustaining procedures.

"Comatose" means: in a state of coma, i.e., a profound state of unconsciousness from which the person cannot be roused by stimulation.

"Cognitive sapient state" means that one does have those functions of the mind concerned with reasoning, understanding or being aware of the environment, objects of thought or perception.

*"Life-sustaining procedure" means any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore or supplant a vital function of a person suffering from a terminal condition and serves only to artificially prolong the moment of death, or when death is imminent, whether or not such procedures are used.

> *Note: "Life-sustaining procedures" do <u>not</u> include the usual care provided to individuals, which would include routine care necessary to sustain patient comfort and the usual and typical provisions of nutrition which, in the medical judgment of the attending physician, a patient can tolerate. This can be interpreted as providing the usual and customary feeding, bathing, turning, pain relief and other such patient care routines a facility normally provides a patient whether or not they meet the above conditions.

Once the attending physician determines a patient has met all of the above, then a committee must confirm the patient's condition. This committee shall consist of two or more physicians other than the attending physician licensed by the Oregon Medical Board. This committee shall be appointed by the medical staff of the facility, or if the facility does not have an organized medical staff, the facility shall appoint such a committee.

Confirmation of the patient's condition shall be documented and be made a part of the patient's medical record.

A good faith effort shall be made by the attending physician to determine that the patient has not executed a "Directive to Physicians." Such a good faith effort would include asking the patient's family or other physicians who recently may have treated the patient. A memo of such inquiries should be documented in the medical record.

Once all of the above steps have been completed, the attending physician shall consult with the first of the following who can be reasonably located: (a) spouse; (b) guardian, if any; (c) a majority of the adult children; or (d) either parent.

The duty of locating the above is the facility's. The steps taken to locate these persons should be document and communicated to the attending physicians.

The statute allows the first of the above to request to have life-sustaining procedures withdrawn. Wherever possible, get this request in writing signed by the person requesting. If this is not possible, get the best signature of make a memorandum of the situation. All documents shall be placed in the patient's medical record.

While the statute only requires one of these persons to authorize withdrawal, if there appears to be a disagreement among the family members, request the family to resolve the problem among themselves before proceeding. This is the family problems – not that the physicians and hospital employees.

If there is serious doubt, a court order can be obtained, preferably sought by the family.

If all of the above procedures have been completed, documented and placed in the medical record, life-sustaining procedures may be withdrawn upon the direction and under the supervision of the attending physician.

If there are no family members or guardian of the patient, the attending physician may direct and supervise the withdrawal of life-sustaining procedures.

Physician Checklist

1. No Directive to Physician has been executed.
2. Is patient comatose?
3. Is there no reasonable possibility that the person will return to a cognitive sapient state?
4. Has the physician determined that the patient suffers from a terminal condition, as that term is defined in ORS 97.050(6)?
5. Have life-sustaining procedures been implemented?
6. Has the patient's condition been confirmed by a committee of physicians appointed by the medical staff, or if none, appointed by the health facility?
7. Has the health facility used and documented reasonable efforts to locate the family or guardian?
8. Has the family or guardian requested the withdrawal of life-sustaining procedures?
9. Has the request been documented?

If all of these questions can be answered affirmatively, then life-sustaining procedures can be withdrawn.

However, if the physician and health care facility must continue to provide routine care necessary to sustain patient comfort and the typical provision of nutrition which the physician believes the patient can tolerate.

APPENDIX H: ACCOUNTABLE CARE ORGANIZATIONS (ACOs) PRINCIPLES

The OMA adopts the following Accountable Care Organization (ACO) principles developed by the AMA:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.
   a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.
   b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
   c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
   d. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in

Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the "shared savings" model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
   a. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
   b. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
   c. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
   d. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
   e. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

APPENDIX I

APPENDIX I: PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

1. The OMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

   PRINCIPLES:
   Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

   Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

   Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

   Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

   Quality and safety are hallmarks of the medical home:
   Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

APPENDIX J

APPENDIX J: CULTURAL COMPETENCE

Cultural Competence, as defined in the Oregon CCO Contract, refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. OAR 415-056-0005. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.

Cultural Competence is a component of true clinical competence.

Cultural Competence is a necessary set of skills for physicians who wish to deliver high quality care to all patients (Betancourt, *NEJM* 2004, NOOK edition).

Effective health care incorporates the cultural traditions and spiritual concerns of the patient and his/her family (Rundle, *Cultural Concepts in Health Care,* Kindle edition).

Providers need a culturally sensitive attitude, appropriate cultural knowledge, and flexible enough skills to provide culturally relevant and effective care for the patients of diverse backgrounds (Wen-Shing Tseng and Jon Streltzer, *Cultural Competence in Health Care,* Kindle Edition, p. 12).

Cultural Competence requires accepting responsibility for one`s own education (Purcell, *Culturally Competent Health Care*, Kindle edition).

Cultural Competence is not a "condition" that is rapidly achieved. Rather it is an on-going process of growth and development of knowledge (Spector, *Cultural Diversity in Health and Disease*).

The OMA will work with its members, Other health care providers and their organizations, and other community organizations to continue the study and implementation of cultural competence for individuals and for health care settings/organizations.

For detailed information, see the following guidelines:

Healthy People 2020 Objectives for Health Communication:
www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=18

Healthy People 2020 Objectives for Health Care Access:
www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=1

National Standards on Culturally and Linguistically Appropriate Services (CLAS):
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

Office of Minority Health:
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=3

APPENDIX K

APPENDIX K: FIREARM INJURY PREVENTION TASK FORCE REPORT

1. Adoption of the following principles, with integration into *Where We Stand, A Guide to OMA Policy Statements:*

1. Firearm injury is a public health epidemic that affects all ages, races, and socioeconomic levels. The sequelae from firearm injury threatens the welfare and well-being of all Oregonians. Methods to reduce firearm-related injuries and deaths should be broad and comprehensive.

2. Gun ownership is valued by a substantial percentage of the population, including a portion of healthcare providers. Laws and policies to reduce firearm-related deaths and injuries should be evidence-based and consistent with the constitutional right of firearm ownership.

3. Deaths and injuries related to firearms are preventable. Firearm-related deaths and injuries can be reduced in Oregon.

4. Effective screening, assessment, counseling, and restricted access to firearms among high-risk individuals can preserve life and function.

5. Physicians and other healthcare providers have a responsibility to take action, lead public health efforts, and inform evidence-based legislation to reduce firearm injury and death.

6. Physicians and other healthcare providers must have unrestricted ability to discuss firearm safety, screen at-risk patients, and counsel patients and their families to avoid firearm injury.

7. Addressing key factors, including mental health crises, domestic violence, and alcohol misuse, are important aspects of reducing firearm injury.

8. Changing how violence is portrayed in society is a crucial step towards reducing firearm injury. The depiction of violence in the media, television, movies, and other aspects of society desensitizes the public and contributes to a culture of violence.

9. Expanded efforts in clinician training and public education about firearm injury are needed. These educational efforts should cut across all demographics and ages, representing all populations affected by firearm injury.

10. Research and research funding are needed to guide evidence-based methods to reduce firearm injury and deaths. Data collection, data sharing, and other efforts related to firearm research should be strongly supported across communities, agencies, and organizations.

2. That the OMA support the following strategies to reduce firearm-related injuries and deaths in Oregon

- Universal background checks for all individuals purchasing firearms, including closure of loopholes that circumvent the screening process
- Ammunition background checks
- Mandatory waiting periods for firearm purchase
- Restricted access to firearms among persons at risk of harming themselves or others
- Restricted access to firearms among persons with a history of alcohol misuse, including alcohol-related legal infractions
- A rigorous permit-to-purchase system for all firearm purchases
- Safe firearm storage laws (unloaded, gun safes, and gun locks)
- Child access protection laws to protect children from unsafe storage of firearms
- Firearm identification with owners (e.g., ballistic fingerprinting or micro stamping)
- Mandatory reporting of lost or stolen firearms
- Prohibition of firearm purchase or possession by persons with a domestic violence restraining order
- Restricted access of firearms for persons convicted of violent misdemeanors
- Ban on semi-automatic assault weapons, large capacity magazines, and other devices designed for rapid killing capacity
- Restriction of all products intended to prevent firearm detection or tracing (e.g., 3-dimensional printing for firearms)
- Informed and effective clinician assessment of patients at risk of self-harm, including those with mental health crises and alcohol abuse
- Increased capacity and patient access to mental health treatment in Oregon
- Development of an evidence-based firearm curriculum, up-to-date resources, current statistics, and methods for implementing firearm-related counseling by health care providers
- Formal integration of firearm injury education into medical training programs, including schools and residency programs
- Promotion of ongoing Continuing Medication Education opportunities that follow an evidence-based curriculum
- Alignment of education efforts toward reducing firearm injury with OMA partners, stakeholders, and related healthcare organizations
- Development of partnerships with other states and organizations to promote congruity between state firearm laws and data sharing for firearm research

3. That the following report be adopted as an appendix in *Where We Stand*

Background

Worldwide, the United States is second only to Brazil in total number of firearm deaths per year.[1] The U.S. is also second in the age-adjusted rate of firearm suicide and is a leader in the age-adjusted rate of firearm homicide among industrialized nations.[1,2] Two thirds of firearm-related deaths in the U.S. are due to suicide, with one third from homicide, and a small number from accidents.[2] While mass killings in public places represent a small percentage of all firearm-related deaths,[2] these events receive widespread media coverage and have changed the way Americans interact with one another. Active shooter safety drills are now routinely practiced in schools, hospitals, malls, and other settings.

The age-adjusted firearm fatality rate in Oregon is higher than the national average, as is the percent of firearm deaths due to suicide (82.1%).[3] From 2010 to 2014, 2,280 Oregonians died from firearms, about one person per day.[4] Guns are also commonly implicated in intimate partner violence. From 2003 to 2012, 256 people in Oregon were killed due to intimate partner violence, the majority of which were women and involved firearms.[5] Firearm-related death and injury remain at epidemic levels nationally and in Oregon, representing preventable death and disability.

Understanding the magnitude, severity, and potential solutions to public health problems requires data and research. However, there have been broad, systematic efforts to suppress firearm research in the U.S. In 1996, a congressional appropriations bill was passed that prohibited the Centers for Disease Control and Prevention from funding research related to gun control, with subsequent extension to other federal agencies, including the National Institutes of Health.[6,7] In 2003, Congress imposed restrictions on sharing information about guns used in crimes, which prevented access to key electronic data sources. More recently, a provision inserted into the Affordable Care Act forbade federal health programs from collecting or disclosing information about firearm ownership. As a result of these efforts, firearm research has received only 1.6% of predicted research funding and 4.5% of predicted publications, relative to its mortality burden.[8] Intentionally preventing research on firearms essentially permits preventable deaths and injuries from firearms to continue.

To address these concerns, the Oregon Medical Association (OMA) approved development of a Firearm Injury Prevention Task Force in June 2018. Healthcare providers were selected from around the state, representing a range of perspectives, including those of gun owners. The Task Force met monthly, researched the evidence base, and developed a set of recommendations based on the best available evidence. This document includes a list of guiding principles, summary of Task Force recommendations, and detailed reports from each of the four workgroups (suicide; provider education; access and storage; and regulations and oversight). The recommendations are synergistic with one another. That is, implementation of multiple recommendations (rather than just one or two) is likely to have a more profound effect on reducing morbidity and mortality related to firearms, while respecting constitutional rights. Some legislative recommendations have already been implemented in Oregon (e.g., restricted firearm access for persons with a domestic violence restraining order, extreme risk protection order), but are included here for completeness and to affirm their protective benefit.

Suicide and Firearms

Suicide is the most common cause of firearm-related fatalities nationally and in Oregon.[2,3] While 62% of firearm fatalities are due to suicide in the U.S., they represent 82% in Oregon.[3] In 2016, there were 513 firearm-related deaths in Oregon, most of which were from suicide. Regions in the U.S. with high suicide rates tend to be more closely aligned to the proportion of homes with firearms than to rates of mental illness.[9] It is also clear that mental illness is not a risk factor for violence, but is a major risk factor for suicide.[10] Access to firearms increases suicide attempt lethality by increasing the likelihood that suicide attempts will involve guns.[11] The risk of completed suicide is also dramatically higher among persons with previous self-harm events involving firearms.[12]

Reducing Firearm Access During Times of Elevated Risk

The majority of suicidal crises are impulsive and fleeting,[13] often lasting less than one hour,[14] providing a narrow window to intervene. The ready availability of a lethal method affects its use, particularly for firearms.[15] Recent purchase of a handgun has been strongly associated with suicide, beginning within one week of purchase.[16,17] The case fatality rate of firearm-related suicide attempts is the highest of all methods.[18] Therefore, interventions that delay the availability of firearms during suicidal crises are critical to reducing suicide-related deaths.[19] Reductions in household firearm ownership have also been associated with reductions in suicide, including those involving children.[20] Mandatory waiting periods for firearm purchases are associated with a reduction in firearm-related suicides, particularly among persons 55 and older[21] and waiting periods specific to handguns.[22] Oregon currently has no waiting period for gun purchase.

Alcohol and Suicide

Alcohol misuse is a common risk factor in firearm-related suicide.[23] Alcohol increases impulsivity, which is a pivotal factor in suicide attempts. Acute and chronic alcohol misuse is associated with increased risk of interpersonal and self-directed firearm violence,[23,24] providing a modifiable target for reducing such violence. Restrictions to firearm ownership among individuals who misuse alcohol (e.g., alcohol-related legal infractions) have been implemented in 37 states as a strategy for reducing firearm-related violence,[23] though not in Oregon.

Legislative Strategies to Reduce Firearm-related Suicide

Laws that reduce firearm-related suicide generally involve limiting access to firearms during periods of impulsivity associated with suicidal thoughts. Examples of such legislative efforts include: universal background checks;[25-29] ammunition background checks;[28] mandatory waiting periods for purchase;[21,22] restricting firearm access for persons with alcohol-related legal infractions or hospitalizations;[23] permit-to-purchase laws for handguns;[29,30] requirement of gun locks to store handguns;[27] and methods to identify firearms with their owners (e.g., ballistic fingerprinting or microstamping).[28] Oregon currently has an “extreme risk protection order”, which allows a court-ordered moratorium on purchasing or possessing a firearm among persons in danger of harming themselves or others. Oregon also requires background checks for purchases, including private party sales (although there are ways to circumvent this process). However, there are no Oregon laws for permit-to-purchase, safe storage, background checks for ammunition, or methods to link firearms with owners.

The Task Force recommends:

1. Informed and effective clinician assessment of patients at risk of self-harm, including those with mental health and/or alcohol abuse;
2. Increased capacity and patient access to mental health treatment in Oregon;
3. Universal background checks, with closure of loopholes that circumvent this process;

4. Ammunition background checks;
5. Mandatory waiting periods for firearm purchase;
6. Restricted access to firearms among persons at risk of harming themselves or others;
7. Restricted access to firearms among persons with a history of alcohol misuse, including alcohol-related legal infractions;
8. A rigorous permit-to-purchase system for all firearm purchases;
9. Requirement for safe firearm storage (unloaded, gun safes, and gun locks); and
10. Firearm identification with owners (e.g. ballistic fingerprinting or micro stamping).

Clinician Education and Firearms

Clinicians receive little training in methods to reduce firearm violence, including how to discuss firearm injury prevention with patients and families and calling upon current firearm laws to protect patients. While more research is needed to identify the most effective methods for screening and intervention, there are multiple sources of educational materials to educate and train clinicians.

Screening and Counseling by Healthcare Providers

The majority of firearm-related deaths in Oregon are from suicide,[3] thus educational efforts should target screening for depression, suicidality, alcohol misuse, and counseling on safe storage. A comprehensive review of 72 articles concludes that providers "rarely" screen or counsel patients and families about firearm safety, even among high-risk patients.[31] However, interventions targeted at healthcare providers can increase rates of firearm safety screening, counseling, and safe storage for high-risk patient groups.[31] Also, patients and families are generally open to such screening and counseling.[31] Seventy five percent of parents believe their child's pediatrician should ask about safe firearm storage, which is similar among gun owners and non-owners.[32] Importantly, talking to patients and families can change behavior around firearms. Discussing gun safety, providing a brochure, and a gun lock, increased the rate of safe gun storage when compared with a control group.[33,34] Screening for cognitive impairment in the context of firearm safety is another potentially important focus for providers.[35]

Educating Healthcare Providers

Clinicians play a unique and vital role in screening and counseling patients at risk for firearm injury. It is important that all providers are knowledgeable about firearm-related state and federal laws, and are comfortable discussing these topics with patients and their families. For example, Oregon clinicians should be familiar with Oregon firearm laws related to domestic violence and the extreme risk protection order.

Developing a Firearm Curriculum for Healthcare Providers

An evidence-based educational curriculum for providers on firearm injury prevention should include description of risk factors for gun violence, methods for discussing ways to reduce firearm injuries, safe storage, and relevant state and federal laws. Existing curricula could be adapted by the OMA to help educate clinicians on these topics, including integration to medical training programs and continuing medical education requirements. Better training in identifying high-risk situations and reducing patient risk will increase clinician confidence and effectiveness in eliminating firearm injuries.

The Task Force recommends:

1. Development of an evidence-based firearm curriculum, up-to-date resources, current statistics, and methods for implementing firearm-related counseling by Oregon healthcare providers;
2. Formal integration of firearm injury education into medical training programs, including schools and residency programs in Oregon;
3. Promotion of ongoing Continuing Medication Education opportunities that follow an evidence-based curriculum; and
4. Alignment of educational efforts on eliminating firearm injury with OMA partners and other national and statewide healthcare organizations.

Access and Storage

Unrestricted access to firearms can result in preventable harm and death. Loaded and unlocked guns increase the number of preventable injuries and deaths related to firearms, particularly among high-risk persons. The National Rifle Association states "firearm education and safety is paramount…to promote the safe handling, use and storage of firearms."[36]

Safe Storage

Recent purchase of a handgun has been associated with an increased risk of violent death.[16,17] Safe storage is an important aspect of firearm safety because most guns used for self-harm or unintentional injuries originate from the home of the victim, a friend, or relative.[37] A case-control study found that storage of locked and unloaded guns, plus locked ammunition stored in a separate location each have a protective effect.[38] Relative to firearms that were unlocked and loaded, those stored locked and unloaded were 84% less likely to be involved in a shooting.[38] Oregon does not legally require gun owners to lock or securely store guns when not in use.

Child Access Protection Laws

According to a 2018 study, 4.6 million children live in a household with at least one unlocked and loaded firearm, representing 7% of all children in the U.S.[39] This proportion varies considerably across states.[40] Safe storage is critically important for children because 89% of unintentional pediatric firearm injuries occur in the home.[41] Incidents where children have unintentionally shot other children are often related to finding a gun unlocked.[42] Storing household guns as locked, unloaded, and separate from ammunition is associated with significant reductions in the risk of unintentional and self-inflicted firearm injuries and deaths in children.[43] Child Access Prevention (CAP) laws hold gun owners accountable for the safe storage of firearms, imposing liability for failing to take preventative measures against guns falling into the hands of children. Strong CAP laws are associated with a 30% reduction in pediatric firearm injuries, with even greater risk reduction against self-inflicted and unintentional injuries.[43] However, there is large variability in these laws across states.[43] CAP laws generally specify criminal liability for persons who negligently store firearms where minors could gain access, even when the firearm is unloaded. Some states specify civil liability for damages resulting from the discharge of a firearm stored negligently when a minor gains access, or the requirement that all firearms be stored with a locking device. Oregon has no CAP laws.

Impact of Physician Counseling on Safe Storage

There is a positive impact on behavior following physician counseling about firearms. In a case-control study of over 1,200 patients who received either verbal counseling about safe storage or verbal counseling plus written information, 58% of participants made a change in safe gun

storage compared with 33% of the control group.[34] The effectiveness of counseling was further increased by providing concurrent written material.[34]

Stolen Guns

Gun theft is common in the U.S., with approximately 380,000 guns stolen each year following legal purchase.[44] This situation creates an ongoing source of weapons, some of which may be used for violence. The mass shooting at the Oregon Clackamas Town Center in 2012 was committed using a stolen gun. Oregon law does not mandate that gun owners promptly report when their firearms have been stolen. The lack of regulation around stolen guns allows for lack of accountability in firearm-related injuries.

Intimate Partner Violence Involving Firearms

Intimate partner homicide rates are higher in regions with greater access to and less restrictions on firearms.[45] From 2003 to 2012, 256 people in Oregon were killed due to intimate partner violence, 82% of whom were women.[5] Firearms are a common mechanism for death from intimate partner violence, which also frequently involves alcohol or substance use by perpetrators.[5] In 2016, 45% of female homicide victims in Oregon were killed by an intimate partner.[46] Prohibition of firearm purchase or possession for persons with a domestic violence restraining order is associated with a 10-19% reduction in intimate partner homicides.[47,48] Current law in Oregon restricts firearms from persons with a domestic violence restraining order.

The Task Force recommends:

1. Safe firearm storage laws to reduce injuries and deaths from firearms;
2. Mandatory reporting of lost or stolen firearms;
3. Prohibition of purchase and possession of firearms by persons with a domestic violence restraining order; and
4. Child access protection laws to protect children from unsafe storage of firearms, including gun owner legal responsibility for discharge of a firearm stored negligently.

Regulation and Oversight

History of Federal Gun Regulation in the United States

While there are federal regulations on firearms, these regulations have become more permissive over time. The National Firearms Act of 1934 imposed a statutory excise tax on the manufacture and transfer of certain firearms and mandated the registration of those firearms. The Federal Firearms Act of 1938 imposed a federal license requirement on gun manufacturers, importers, and persons in the business of selling firearms, plus a requirement to maintain customer records and prohibition of sale to certain classes of persons, such as convicted felons. The Gun Control Act of 1968 replaced the National Firearms Act and Federal Firearms Act. This act regulates interstate transfer of firearms, requires imprinted serial numbers on firearms, and has record-keeping requirements to allow law enforcement to trace firearm transfers. Federal regulations require individuals purchasing a firearm to sign a form stating they are not convicted felons or otherwise disqualified under federal law, but there is no obligation for the gun dealer to verify this claim. Firearm transfers by private gun owners are not regulated. The Firearm Owners Protection Act of 1986 revised and weakened many provisions of the Gun Control Act, including language that the government would not maintain a database of firearm purchases. The Brady Handgun Violence Prevention Act of 1993 mandated federal background checks on firearm purchasers through the National Instant Criminal Background Check System maintained by the FBI. However, firearm transfers by unlicensed private sellers that are "not engaged in the

business" of dealing firearms are not subject to the Brady Act and other methods have been developed to circumvent this law. The Protection of Lawful Commerce in Arms Act of 2005 protects firearms manufacturers and dealers from being held liable when crimes have been committed with their products. Several federal laws, including the federal ban on semi-automatic assault weapons and high-capacity magazines, have expired or been repealed.

Restricting Firearm Possession by Violent Criminals

Restricting firearm possession by violent criminals has the potential to reduce future gun-related violence and crime. Despite federal regulations, legal gun ownership by offenders imprisoned for crimes committed with a firearm remains common, yet stricter state gun laws could potentially reduce repeat firearm-related offenses.[49] Domestic violence restraining order provisions that prevent persons from buying or possessing firearms have been shown to reduce intimate partner homicide rates.[47,48] In a study that compared individuals arrested but not convicted of a felony (able to purchase firearms) with individuals convicted of felonies (unable to purchase firearms), those approved to purchase a handgun were 21% more likely to be subsequently arrested for a crime involving a gun and 24% more likely to be arrested for a violent crime.[50] Handgun purchasers with a prior misdemeanor are also at increased risk for committing future firearm-related crimes.[51] Laws denying handgun purchase to persons previously convicted of violent misdemeanors reduces new gun and/or violent crimes.[52]

Legislation Preventing Access to Firearms by Criminals

Federal firearm laws are principally aimed at keeping firearms out of the hands of criminals and basic record-keeping to assist law enforcement with investigation of firearm-related crimes. Increasingly, evidence suggests that federal firearm laws are lax and easily circumvented by criminals, leaving more rigorous legislation up to individual states. Some states have enacted permit-to-purchase policies to better regulate access to firearms. The conditions of these policies vary from an online application to fingerprinting and photography. States with more rigorous registration and licensing systems have a lower rate of purchased guns being recovered in crimes.[53] States with rigorous permit-to-purchase systems, comprehensive background checks, and mandatory theft/loss reporting curtail diversion of guns to criminals, but these benefits can be offset by an influx of guns from states with weak regulations.[54] The repeal of a permit-to-purchase law in Missouri was associated with a 25% increase in firearm homicide rates, despite no change in non-firearm homicides.[55] Banning high-risk handguns can also reduce the use of these weapons among criminals.[56] Oregon does not have a permit-to-purchase law, mandatory reporting of lost guns, or linkage of firearms to their owners.

Semi-Automatic Assault Weapons and Large Capacity Magazines

Starting in 1994, there was a federal law banning semi-automatic assault weapons and large capacity magazines in the U.S., which was allowed to expire in 2004. During the ban, gun crimes involving these weapons decreased, but this decrease was offset by the use of other guns equipped with large capacity magazines exempted from the ban.[57] Semi-automatic assault weapons are used in a minority of gun crimes (although their use as crime guns has been increasing since expiration of the ban), but they are used in the majority of firearm-related mass murders.[58] In 1996, Australia passed major gun law reforms, including a ban on semi-automatic weapons in response to a mass shooting incident. For 20 years following this ban, there have been no mass firearm killings in Australia.[59] While firearm-based mass shootings constitute a small percentage of all firearm-related deaths,[2] these events have had a profound effect on society, including children. The integration of active shooter drills in U.S. schools is now routine.

While bans on semi-automatic weapons may not have a notable overall effect on gun crime,[57] they have a large effect on reducing the incidence of mass shootings.[59,60] Oregon has no laws related to semi-automatic assault weapons or large capacity magazines.

The Task Force recommends:

1. Prohibition of firearm purchase or possession by persons with a domestic violence restraining order;
2. Restricted access of firearms for persons convicted of violent misdemeanors;
3. Mandatory reporting of lost or stolen firearms;
4. Universal background checks for all individuals purchasing firearms, including closure of loopholes that circumvent the screening process;
5. A rigorous permit-to-purchase system for all firearm purchases;
6. Ban on semi-automatic assault weapons, large capacity magazines, and other devices designed for rapid killing capacity;
7. Restriction of all products intended to prevent firearm detection or tracing (e.g., 3-dimensional printing for firearms); and
8. Development of partnerships with other states and organizations to promote congruity between state firearm laws and data sharing for firearm research.

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APPENDIX L

APPENDIX L: AMA 2019 OPIOID TASK FORCE RECOMMENDATIONS

The OMA participates on the AMA Opioid Task Force comprised of the American Medical Association, American Osteopathic Association, and 25 specialty and state medical societies as well as the American Dental Associations.

American Medical Association
American Osteopathic Association
American Academy of Addiction Psychiatry
American Academy of Family Physicians

American Academy of Hospice and Palliative Medicine
American Academy of Neurology American
Academy of Orthopaedic Surgeons
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons and Congress of Neurological Surgeons
American College of Emergency Physicians
American College of Occupational and Environmental Medicine
American College of Physicians American College of Obstetricians and Gynecologists
American Dental Association
American Psychiatric Association
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Clinical Oncology
Arkansas Medical Society
California Medical Association
Massachusetts Medical Society
Medical Society of the State of New York
New Mexico Medical Society
Ohio State Medical Association
Oregon Medical Association
Utah Medical Association

The AMA has issued recommendations in the past focused on those ways in which physicians could take specific actions to help reverse the opioid epidemic. With the inclusion of all specialty societies and several states, the AMA has issued reports that demonstrate progress in several areas around the Prescription Drug Monitoring Programs (PDMPs), necessary education to ensure education and training on effective, evidence-based treatment, to support and advocate for comprehensive care for patients in pain with a substance use disorder (SUD), to remove the stigma associated with SUDs, to expand naloxone access in the community and to work with patients to promote safe storage and disposal of opioids and all medications.

The OMA Policy committee, in its discussion of the opioid issues in July 2019, requested that the Opioid Task Force review the AMA's policies for possible consideration as a task force recommendation.

These recommendations are listed below:

1. **Remove prior authorization, step therapy and other inappropriate administrative burdens or barriers that delay or deny care for FDA-approved medications used as part of medication-assisted treatment (MAT) for opioid use disorder (OUD).**

In the midst of an epidemic, and given the clear evidence in support of MAT as a proven medical model to support recovery, save lives, reduce crime and improve quality of life, the AMA Opioid Task Force calls on all payers—commercial insurers, self-insured plans, Medicare, Medicaid—as well as pharmacy benefit management companies (PBMs) to end prior authorization and other unnecessary utilization management protocols for the treatment of opioid use disorder. This also includes ensuring that MAT is available on the lowest cost sharing tier to promote affordability as well as prompt availability. Multiple payers in states (e.g.

Maryland, New York, Pennsylvania) already have taken these steps—now it is time for all payers to support increased access to MAT.

2. Support assessment, referral and treatment for co-occurring mental health disorders as well as enforce meaningful oversight and enforcement of state and federal mental health and substance use disorder parity laws.

Very high rates of mental health disorders co-exist among patients with opioid use disorders as well as among patients with chronic pain conditions leading to increased risk for suicide. The 2017 National Survey on Drug Use and Health found, however, that 92 percent, or 19.7 million people, with a substance use disorder receive no treatment, and 57 percent, or 46.6 million people, with a mental illness receive no treatment. The Task Force continues to urge physicians to appropriately assess and refer patients for substance use and mental health disorder treatment. At the same time, the Task Force notes that the federal Mental Health Parity Addiction and Equity Act is more than 10 years old, and to improve access to care and reverse the effects of the opioid epidemic, the Task Force believes that insurers need to be held accountable for complying with their legal obligations. This means that health insurance companies must have addiction medicine, addiction psychiatry and psychiatric physicians not only in the network but accepting new patients as well as mental health and substance use disorder parity coverage that is on par with medical and surgical benefits. Anything less is unacceptable.

3. Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs.

The AMA Opioid Task Force supports patients having access to the right treatment at the right time without administrative barriers or delay from health insurance carriers or other payers and pharmacy benefit or behavioral health management companies. There is no question that the nation's physicians have reduced opioid analgesic supply—both in volume and dose strength—but there has not been a concomitant increase in access to or affordability of evidence-based non-opioid alternatives. The Task Force further notes that the therapies listed below may not be appropriate for all patients, which is why enhanced education and access to pain and palliative medicine specialists also is encompassed as part of this recommendation. As part of current and future efforts to reverse the nation's opioid epidemic, the Task Force supports increased research and access to evidence-based treatment, including: Medication, including non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics as well as opioid analgesics when appropriate.

The Task Force notes that physicians and patients now face a multiplicity of new laws, guidelines and policies from payers, PBMs and national organizations, which are often contradictory. • Restorative therapies, which include physical therapy, occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT), and other modalities such as massage and therapeutic ultrasound. • Interventional procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections, and other emerging interventional therapies as part of the multimodal pain care plan.

This recommendation further calls for more detailed regulatory review of formulary and benefit design by payers and PBMs to ensure that patients have affordable, timely access to evidence-based non-opioid alternatives, pharmacologic and non-pharmacologic. In conducting such

reviews, the Task Force urges policymakers to work closely with physicians to ensure appropriate clinical input.

The Task Force further affirms that some patients with acute or chronic pain can benefit from taking prescription opioid analgesics at doses that may be greater than guidelines or thresholds put forward by federal agencies, health insurance companies, pharmacy chains, pharmacy benefit management companies and other advisory or regulatory bodies. The Task Force continues to urge physicians to make judicious and informed prescribing decisions to reduce the risk of opioid-related harms, but acknowledges that for some patients, opioid therapy, including when prescribed at doses greater than recommended by such entities, may be medically necessary and appropriate.

4. Support maternal and child health by increasing access to evidence-based treatment, preserving families, and ensuring that policies are non-punitive.

The Task Force believes it is essential to specifically highlight the important roles of physicians and policymakers in ensuring the unique needs of pregnant, postpartum and parenting women and children are met. OUD among women of reproductive age and pregnant, postpartum and parenting women has increased over recent years, mirroring the epidemic seen in the general population. According to the U.S. Department of Health and Human Services Office of Women's Health, the number of women dying from overdose of prescription drugs rose 471 percent between 1999 and 2015, compared to 218 percent for men, and heroin deaths among women increased at more than twice the rate of men. MAT is the recommended evidence-based treatment for pregnant and breastfeeding women with OUD. Threats of incarceration, immediate loss of child custody, and other potential punishments drive pregnant, postpartum and parenting women away from vital prenatal care and treatment. Research has found that non-punitive public health approaches to treatment result in better outcomes for both moms and babies. The Task Force believes that additional efforts are needed for patient and public education as well as outreach to policymakers to ensure evidence-based care guides treatment options for maternal and child health.

5. Support reforms in the civil and criminal justice system that help ensure access to high quality, evidence-based care for OUD, including MAT.

The AMA Opioid Task Force believes that all persons entering jails or prisons (both for men's and women's facilities), while incarcerated, and upon release, will benefit from enhanced opioid use disorder screening protocols to identify those persons arrested if they are currently on MAT, or would like to begin treatment. The Task Force also supports the use of evidence based protocols for maintaining continuity of care for persons released from jail or prison, including—as necessary—enrollment in Medicaid, coordination with peer counseling or other services to ensure the person has linkages to treatment providers in the community, and other such services so as to maintain access to and a continuum of care to sustain and promote recovery. This recommendation also applies drug courts and other diversion services to support evidence-driven care for persons with an opioid use disorder.

The OMA remains committed to supporting future efforts to address all substances of abuse and addictive potential beyond prescription opioids and emphasizes the importance of maintaining the integrity of the provider-patient relationship. This includes but is not limited to the review and recommendation for state guidelines when appropriate. Representatives of OMA currently

participate on the Governor's Opioid Epidemic Task Force, the AMA Opioid Task Force, the OHA Tapering Guidelines Workgroup and the PDMP workgroup.

APPENDIX M

APPENDIX M: EQUITY TASK FORCE REPORT: EQUITY IN THE MEDICAL PROFESSION

The OMA supports the following principles related to equity and inclusion in the medical profession:

1) The OMA is committed to improving diversity, equity, and inclusion within the medical community and to being an antiracist organization.

2) Patient care benefits when the medical workforce at all levels and in all specialties reflects the diversity of our communities.

3) The OMA affirms the importance of ongoing collection of data and measurements of inequities for impacted groups to create transparency and accountability. We must respect the sensitivity of information collected but must understand the barriers to improved workforce diversity in order to overcome them.

4) The OMA will work to further an inclusive and supportive environment within medicine. Recognizing the burdens to be overcome by individuals facing barriers, the OMA will offer mentorship opportunities and promote policies resulting in active recruitment and support of a more diverse workforce.

5) The OMA recognizes alternate and nontraditional career pathways and supports them as to ensure the growth of and sustain diversity within the workforce and medical community.

    a) Those caring for children, elder family members, or others with increased needs carry burdens and assume responsibilities that should be highly valued in the profession. Taking on this responsibility demonstrates traits congruent with the calling to a life of service in medicine, and retention of these members of our professional community must be a priority. Traditional cultures and systems within the profession must change to allow all members of our professional community to continue to contribute, even when other life burdens make this challenging.

    b) A shift in medical traditions must allow alternate career pathways to include recognition and rewards for work done to further the goals of a diverse workforce.

    c) A shift in culture must also improve the retention, and hence equity, of the medical workforce by recognizing that overcoming barriers is a task to be shouldered by the whole community.

6) The OMA will increase representation of diverse members of the medical community within the organization and its own leadership.

7) The OMA encourages institutions that intersect any part of the pathway in medicine to actively work to increase recruitment to and retention within the medical professions of diverse members.

8) The OMA affirms that physicians and physician assistants deserve equal compensation for the same work as their peers, without regard to gender, race, ethnicity, religion, sexual orientation, and gender identity; or other factors that have placed people at risk of discrimination. This will require further evaluation of salary inequities by race, gender, and other minority status, as well as development of transparent compensation strategies and advancement metrics.

9) The OMA recognizes that improvements in equity in the medical profession will increase the wellbeing, safety, productivity, work satisfaction, and opportunities for medical professionals, as well as positively impact health outcomes for communities, patient access to care, and satisfaction with care.

10) Equity issues in the profession and our society will always be a work in progress. Task Force members recognize that not all facets of equity are thoroughly addressed in this document, and the OMA commits to continuing to advance equity work with attention to additional areas, including but not limited to systemic racism, disability communities, international medical graduates, and religion.

Task Force Background

As disparate communities around the world are brought closer together with advances in technology and transportation, the rich population diversity of the United States has the potential to be a catalyst for innovation and cooperation between people of various cultures and backgrounds. This dynamic and diverse population helps promote creativity and advancements by sharing ideas, products, and services across all disciplines. Although diversity in the United States is a great strength and example of freedom, there are certain challenges diversity introduces to the work environment that have not been fully explored and resolved. These challenges have led to persistent inequities in pay, advancement, and inclusion, and to issues with harassment within the workplace, despite legislation intended to provide protections and aspirations for better. The medical profession is no exception.

To help address concerns of equity in the medical profession, the Oregon Medical Association (OMA) launched its Equity Task Force in October of 2019. Physicians, physician assistants (Pas), and medical and PA students were selected as members from around the state, representing a range of perspectives and backgrounds. The Task Force was charged with providing recommendations to guide the state's medical community and the OMA's advocacy work on equity issues related to gender, race, ethnicity, sexual orientation, and gender identity. The work was completed by five workgroups:

- Pathways into medicine
- Workplace culture

- Caregiving responsibilities
- Patient relationships
- Pay

The OMA hopes that this work may increase diversity in the healthcare workforce, improve retention of diverse members within the workforce, and ultimately lead to better care of the state's diverse communities. We believe this can be achieved by increasing the currently available paths into the profession, advancing equitable pay and promotions, improving workplace culture, reducing caregiver stress among clinicians, and supporting the importance of clinician-patient relationships.

The Equity Task Force researched the evidence base regarding the impact of identity characteristics (including gender; ethnic and race groups underrepresented in medicine; and lesbian, gay, bisexual, transgender, queer) on careers in medicine. Members of underrepresented racial and ethnic groups face many barriers when undertaking careers in medicine. Women and members of the LGBTQ+ community also face unique challenges in the clinical, research, and academic settings. Although the Task Force did not specifically focus on the challenges of immigrants, religious minorities, and people with disabilities, improving sensitivity and access related to other equity issues may benefit these populations as well. Additionally, the Task Force recognizes the nuance of intersectional characteristics that together can magnify an individual's level of privilege and exposure to opportunity or risk of bias and setbacks.

Pathways into Medicine

The traditional pathway into the medical profession includes successful completion of grades K-12, a bachelor's degree, pre-medical school requirements, and admission into a professional school. Historically, racial and ethnic minorities, women, and LGBTQ+ individuals have faced barriers throughout this pathway to medicine, which has contributed to the lack of diversity seen in medicine today. Those who exist at the intersection of these nontraditional identities can be even more strongly impeded. The longstanding effort to keep the medical professional homogeneous suggests that a similar conscientious effort, with interventions at various stages in the pathway, will be required to achieve true diversity.

The Task Force Recommends:

1) Opportunities for early exposure to medicine and specialty fields and early contact with mentors from diverse backgrounds in medical professions;

2) Institutionally and state funded financial support for students interested in healthcare careers who have a demonstrated financial need to help with preparation for medical school, including support for living expenses and medical school application expenses;

3) Community programs that aim to create a diverse conduit of students to enter health professions, such as underrepresented minority-directed pre-med immersive programs, youth outreach to inspire early interest by medical students and clinicians, and paid opportunities for high school students to work in medical practices with clinicians;

4) Enhanced funding for quality early childhood through high school education and for parental educational and employment opportunities and benefit programs; these are foundational for economic and housing stability and food security for all at-risk families;

5) Holistic admission criteria for medical schools, removing standardized testing as a requirement and prioritizing recruitment from underserved regions;

6) Inclusion of sexual orientation and gender identity as standard demographic variables collected on medical school (AMCAS), residency (ERAS), fellowship, and other employment applications, as well as on licensing applications, academic appointment applications, and professional society surveys to understand whether current recruitment practices effectively achieve diversity goals;

7) Routine evaluation of what demographic variables are collected on medical school, residency, fellowship, and other employment applications, as well as on licensing applications, academic appointment applications, and professional society surveys to consider additional expansion of this list over time as needed to help understand whether current recruitment practices effectively achieve diversity goals;

8) Opportunities for interaction and longitudinal mentorship with faculty and clinicians in the community, including mentors whose own knowledge or experiences may help mentees navigate issues related to characteristics of diversity during medical school and training;

9) Accreditation standards of training programs that require programs to promote inclusion by requiring demonstrated actions taken to improve diversity;

10) Training for clinicians and healthcare administrators on critical race theory to improve awareness of potential for bias;

11) Decreased weight of Step 1 board examinations and moving toward holistic evaluation in the residency application process;

12) Universal and equal acceptance of COMLEX exams by all US residency programs to decrease the added financial and testing burden placed on underrepresented DO students when they are implicitly expected to take the USMLE series in addition to the COMLEX series;

13) Robust test preparation resources that are integrated into a medical school's curricula to minimize inequality of access to high-quality board prep materials;

14) Change to criteria for honors societies, awards, and opportunities for public speaking and elimination of their use from consideration on applications for training positions, hiring, promotions, and tenure if honors have not been scrutinized for issues of equity; and

15) Increased research in key areas in which the literature related to equity in medicine is lacking. This includes, but is not limited to: impacts of sexual gender minority status on experience of training, access to career advancement, and improvement in clinical care delivered; impacts of improved gender, racial, sexual orientation/gender identity diversity on the quality of care and costs, effective interventions that achieve improved representation, and retention of diversity in the practice of medicine; and reasons for clinicians for reducing work hours and ways to improve full engagement and retention in the profession.

Workforce Culture

A healthy workforce culture is a key enabler in retention of healthcare clinicians, particularly for women clinicians and clinicians from underrepresented minority groups. Workforce culture is multi-faceted, including the existence of discrimination, exposure to violence of many types, clinician burnout, and the abilities for advancement. Significant issues in workforce culture include workplace harassment and violence towards women, the inclusion of LGBTQ+ people, and the inclusion of people of color. Additionally, these groups often experience barriers to equitable advancement opportunities. Efforts are required to remediate existing dysfunction in workforce culture, in addition to the work required to build healthier future foundations of culture.

The Task Force Recommends:

1) Training for leaders at all levels of organizational structure to be change agents for the development of a positive, inclusive, and respectful workforce culture for all members of a diverse healthcare team, with the goal of moving beyond a focus on reducing legal risk and focus on actively altering culture and climate;

2) Funding for research on medical institutional climates to better understand the problems and needs of medical professionals and academic medical centers in Oregon;

3) Requirements for tracking and reporting progress in equity through measurable data on representation by race, ethnicity, gender, sexual orientation, etc., monitoring retention in the profession and institution; and exploring the experiences people have with discrimination and/or violence at regular intervals;

4) Medical school accreditation tied to evidence of active and meaningful leadership to improve representation of women, racial/ethnic minorities, and LGBTQ+ people in all arenas;

5) Resources to reduce isolation within the profession and to develop systems to elevate voices and concerns of disadvantaged groups to institutional attention, with an eye toward improving culture;

6) Integrated and centralized diversity within the mission of an organization and within the organization's leadership ranks;

7) Transformation by medical institutions of their internal culture through enhancing the visibility of diverse populations in leadership positions and diversifying leadership positions at every institutional level, including, but not limited to, board of directors membership, executive-level organizational leadership, management positions, medical directorships, and tenured faculty roles;

8) Publicly reported data on board of directors and C-suite diversity (including trends in diversity over time) from medical institutions within the state;

9) Promotion and tenure policies to be better adapted to reflect and value the career trajectories and contributions of women and underrepresented groups within academic medicine and other medical organizations;

10) Effective mentorship opportunities, either locally or through national organizations, targeting the specific population/demographic group's experience of barriers and challenges;

11) Strong, meaningful representation of diversity on panels involved in recruitment and promotion reviews within a medical institution, as well as ensuring diversity among candidates for hire before closing the search to fill a position;

12) Recognition that racism is a system that assigns value based on how one looks and internal examination of an organization's own policies, practices, norms, and values and how they influence decision-making in order to determine how racism is operating within the institution;

13) Access to educational materials and resources to guide the construction of antiracist interventions within medical institutions, including but not limited to identifying who is missing from the decision-making table and what is "on" versus "missing from" the agenda;

14) Close examination of the historical role of sexism/gender bias and racism in an institution or organization to identify how past decision-making and practice may be influencing current policy and climate; the OMA will start by modeling this work internally;

15) Stricter anti-discrimination policies and protections that actively remove barriers to women clinicians and develop an antiracist culture;

16) Adoption of the 2018 NASEM report recommendations for individual, institutional, and legislative changes to reduce workplace discrimination and violence, which include targeted efforts to improve safe and respectful work environments and organizational culture, addressing the most common forms of sexual and gender harassment;

17) Institutional, local, state, and federal legislation that upholds and strengthens the rights and privacy of survivors of sexual harassment and violence and is survivor-centered, including but not limited to changes made to Titles VII or IX;

18) Use and funding of confidential advocates within institutions to support students and professionals who experience harassment and/or violence, with the role of confidential advocates expanded, and appropriately funded, to also address microaggressions and inequities experienced within the organization, with a goal of shifting institutional culture and mitigating current inequities;

19) Zero-tolerance policies for workplace harassment based on race, ethnicity, gender identity, sexual orientation, religion, parenting or caregiving status, disability, or other unique identity held by individuals in the medical workplace;

20) Routine surveying by educational institutions of medical trainees about gender-based violence;

21) Recognition of the value that unique contributions from women clinicians and underrepresented faculty or clinicians offer by modifying promotions processes to positively weight contributions, including but not limited to, underserved patient care advocacy, community service, and research with underserved and minority patients. Increased time and commitment to mentoring of women and underrepresented clinicians and students; and time and commitment to diversity work within the organization;

22) Education for academic faculty and organizational leaders about existing literature-documented challenges that women and underrepresented clinicians face and methods to overcome those challenges;

23) Implementation of best practices for collecting data on representation of LGBTQ+ clinicians in the workforce and on the pathway to the workforce, including applicants to medical school, residency, and fellowship training;

24) Efforts and initiatives directed at more broadly Implementing early-career debt relief;

25) Performance evaluation criteria and advancement criteria that are explicit and transparent, including the standards for advancement when a clinician works part-time or has a leave of

absence for caregiving responsibilities; to be reviewed annually with employees to identify areas of difficulty and ensure success;

26) Targets for hiring, retention, and advancement of women and underrepresented members of clinical and academic teams and that leadership team reviews, and program accreditation be tied to success in these arenas;

27) Opportunities for leadership training and mentoring in medical organizations, academic institutions, and practices, with a focus on women and other underrepresented clinicians;

28) Family-friendly policies and adjustments to the promotion cycle within organizations that allow for career customization and individualized career plans which span a faculty member's career, with options to flex up or down in research, patient care, administration, and teaching;

29) Increased availability of pilot funds from academic and governmental institutions to lower barriers for research and systematically monitor startup packages for research and academic work to ensure resources are equitably distributed, regardless of demographic differences; and

30) Training for decision-makers of hiring, promotions, and leadership to recognize their own biases and on the organizational imperatives around improving diversity.

Caregiving

Family care responsibilities, both for children and for elders or those with healthcare needs, fall disproportionately on women. Cultural and socioeconomic differences and diverse family structures result in differing impacts on some racial and ethnic groups and LGBTQ+ individuals. These responsibilities can impact pay, advancement opportunities and lead to increased experiences of stress and burnout. Issues relating to balancing family and work must be addressed to achieve a more equitable and diverse workforce.

The Task Force Recommends:

1) Flexible course schedules within medical schools that allow for caregiving for family members, with efforts made to ensure timely graduation and progress;

2) Residency application process and cycles that increase options for trainees who seek to care for family members, such as a second application cycle to minimize unused time off;

3) Family leave policies that are opt-out, as opposed to opt-in, with reasonable wage replacement rates;

4) Gender-neutral parental and family leave that would ensure protection for LGBTQ+ families that otherwise face unequal social and economic treatment;

5) High quality publicly and institutionally supported childcare, including backup care for sick children;

6) Accessible lactation resources in workplace and academic settings and standardized policies regarding scheduling accommodations to support breastfeeding;

7) Opportunities for flexible work schedules;

8) Resources to ensure the provision of childcare in emergency and on-call situations;

9) Increased resources for in-home care for the elderly and reduced-cost high quality options for institutional care; and

10) Increased research on care for older adults by “sandwiched” families.

Patient Relations

Patient bias toward clinicians and clinician bias toward patients can have impacts on the quality of care and the clinicians’ wellbeing. Mismatch in identities can also create problems within the relationship. Negative bias toward a clinician can lead to mistreatment or affect how the quality of care is perceived by the patient. A clinician’s characteristics play a role in which patients will select them for care, leading to panels that are inequitable with regard to workload and revenue generation.

The Task Force Recommends:

1) Increased research on how to improve identity-conscious care;

2) Improved education for trainees and continuing education for practicing clinicians that addresses not just issues of cultural difference, but systemic racism, sexism, homophobia, and transphobia, and provides tools to examine these issues;

3) Self-assessment of institutional bias by healthcare organizations while creating a robust support system for clinicians and other healthcare members;

4) Nuanced approaches to reimbursement to account for differences in patient utilization and care needs;

5) Discrimination reporting systems for both clinicians and patients within healthcare organizations;

6) Funding to increase access to healthcare resources and clinician training in rural settings.

7) Resources for clinicians to adequately assess their appropriate amount of workload in their patient panels and support these findings with appropriate panel assignment;

8) Policies within healthcare organizations that explicitly address patient bias, with a clear mechanism for reporting incidents of patient bias and procedures to inform decisions about future care of the patient and support of the medical staff; and

9) Standardized responses by medical groups and healthcare institutions to be directed to patients who demand different clinicians due to patient bias against clinicians.

Pay

Pay inequity remains a challenge for many populations of healthcare workers, with particular impact on women, ethnic and racial minorities, and the LGBTQ+ population. This impact is felt downstream by our patients in lower worker satisfaction, lower workforce retention, and diminished understanding of community health challenges. The inequities are multifactorial, systemic, and persistent throughout the careers of impacted populations. Factors such as bias in hiring and promotions and payment system type are some of the contributors. Clinician groups must be made aware of the impact on both health outcomes and financial metrics by achieving pay equity. Further research is required, and clinician groups must be encouraged to improve, monitor, and audit pay practices and internal policies. State and federal legislative action will likely be required to align incentives to true pay equity.

The Task Force Recommends:

1) Routine collection of data on pay and total compensation by all large medical groups, academic institutions, and coalitions of smaller groups, carried out with attention to demographic factors and any factors that may account for differences in compensation, with special attention to groups that have not yet been well evaluated;

2) Consideration for protecting privacy and confidentiality in developing methods of data collection and sharing;

3) Governmental support and funding for data collection and pay disparity research;

4) Standardization within medical institutions and groups of starting position salary based on specialty, rank, and region;

5) Omission of questions about previous compensation during the application, interview, and hiring process;

6) Routine audits of total compensation (clinical and non-clinical) for large clinician practices performed by outside consultants, with results of the analysis shared with a diverse supervisory and accountable leadership group or with the division director;

7) Incorporation of equity metrics into quality targets or annual evaluations of organizational leaders;

8) Transparency on how initial and subsequent salary is determined and data on current compensation levels (including information on rank, years of employment, gender, race, and other pertinent demographic data);

9) Adjustments in salaries made if unexplained differences are identified;

10) Compensation based on a broad range of factors that value the overall experience of the clinician beyond FTE and productivity;

11) Implementation of compensation models that reduce inequities, such as: salary-only structured compensation models incorporating national benchmarks and clear standardized pay steps and increments, structured compensation models based on rank and time-in-rank in a given subspecialty, value-based compensation systems, and development of an "academic RVU" measure that can also be used to determine compensation;

12) Public access to national salary data such as the AAMC salary report;

13) Evaluations of compensation that include a comprehensive view of compensation including: retirement benefits, disability/malpractice insurance, health benefits, access to pay for performance or bonuses; research support; division of work between clinical, teaching, committee, and research responsibilities; access to leadership opportunities; and factors impacting clinical workload for individual clinicians;

14) Avoidance of patient satisfaction metrics such as Press Ganey or HCAHPS as factors in deciding compensation, bonus, and advancement unless there are robust data demonstrating that patient bias has no statistical effect;

15) Consideration for differences in risk levels of patient panels when using quality of care measures to determine compensation, to avoid penalizing clinicians for caring for more complex groups of patients;

16) Precise promotion guidelines (e.g. number of papers, size of grants) for academic positions and availability of an experienced senior faculty member who can counsel faculty on readiness for promotion;

17) Consideration of valuation of citizenship work (e.g. committee, mentoring, service work); rewarding activities central to medicine like teaching and committee membership;

18) Specific criteria for earning add-on bonuses available and achievable by all the members of the group, with routine updates on progress toward the goal provided by leadership;

19) Performance reviews coupled to routine assessments for compensation adjustment;

20) Human Resources involvement in countering forces pushing toward compensation inequities, by evaluating job offers to ensure they're based on the value the position brings to the organization and not on what the candidate earned previously, participating in routine pay equity analyses to determine if pay is based on relevant variables like market value, experience, last three performance ratings, utilizing peer group settings to discuss and defend the distribution of raises; and monitoring hiring, promotions, and raises to ensure they are bias free and explicit regarding who is responsible for equitable pay;

21) Term limits for leadership positions;

22) Standardization and transparency related to how decisions about part-time status and family/medical leave impact advancement, bonuses, and expectations about productivity in a given period of time;

23) Research to identify the policies, procedures, leadership, and/or culture that promote equity in some specialties in order to determine best practices and target the effective remedies to disparities in all specialties; and

24) Federal and state legislation to address wage gaps such as the Paycheck Fairness Act.

Advantages of a Diverse Workforce

The goals of improved diversity in the physician and PA workforce include improving patient care and satisfaction, increasing workforce resources in the setting of clinician shortages, advancing the quality of scholarly work, and improving ethics and justice within the profession.

Historically, efforts to increase equity and equality have targeted the barriers a specific group face. However, many people have identities that intersect multiple categories that are more significant when experienced together than would be one single identity characteristic alone. For this reason, the Task Force addresses issues of equity more universally recognizing that issues related to gender, racial and ethnic identities, and sexual orientation and gender identity cannot be examined and addressed effectively alone.

Defining the characteristics that warrant close attention and concern as they appear to represent the most significant barriers to careers in medicine is important when furthering research, understanding, and identifying interventions. According to the Association of American Medical Colleges (AAMC), “underrepresented in medicine” (UriM) is defined as “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.” At the time of this report, these groups include Blacks, Mexican-Americans, Native Americans (American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans.[1] Other populations may also face barriers, but have been more successful at increasing representation in the profession. The Taskforce examined the impact of diversity characteristics on achieving the goals of excellence in our healthcare system.

Gender diversity on medical teams benefits the profession, as well as the people and communities served. There are documented differences in the way women practice medicine, including increased adherence with clinical guidelines and preventive care recommendations, a patient-centered communication style, and longer visits with patients.[2,3,4,5,6] Recent studies demonstrate improved clinical outcomes for patients cared for by women. In one study, elderly hospitalized Medicare patients treated by female internists had lower mortality and readmissions compared with those cared for by male internists.[7] In another study, after accounting for patient, surgeon, and hospital characteristics, it was found that patients treated by female surgeons had a small but statistically significant decrease in 30 day mortality, length of stay, complications, and readmissions compared with patients of male surgeons.[8] The presence of women clinicians may benefit care by adding a different perspective and unique talents, qualities, attributes, and insights.

Other kinds of diversity on medical teams have been shown to add to the effectiveness of the team as well. Racial and ethnic diversity among teaching faculty increases the quality of training for all students in caring for racially heterogeneous populations and promotes scholarly activities related to racial and ethnic health disparities.[9] Racial and ethnic minority clinicians are more likely to practice in underserved communities, including caring for racial minorities and uninsured patients.[10,11,12,13,14] Physician diversity and increased diversity among medical teams is linked to better patient outcomes in primary care.[10] Physician-patient race concordance is associated with higher levels of African American patient satisfaction with care, and improved communication and better pain management are listed as benefits.[15] Ethnic minorities tend to receive better interpersonal care from clinicians/physicians of their own race or ethnicity.[16] Race and gender concordance between Black men and their physicians has been shown to significantly increase uptake of evidence-based effective care.[17]

Race bias produces worse clinical results. White medical students and residents have demonstrated false beliefs about biological differences between Blacks and whites including bias in perception and treatment of pain.[18] Reports of substandard care including omission of physical exams, inappropriate diagnosis/treatment, and difficulty receiving referrals have been reported with discordant physician-patient ethnicity or race.[19] Bias and care quality improves when the diversity of the clinicians increases. The National Academies of Medicine states that a main factor for health inequity for LGBTQ+ patients is the lack of clinician training in this area and limited availability of clinicians with expertise.[20,21] Improved training and competency in the care of LGBTQ+ patients and equal representation of this community in all medical specialties represent methods of improving the delivery of appropriate care to this population.

Healthcare studies show patients generally fare better when care is provided by more diverse teams. Studies outside the healthcare field find improvements to innovation, team communications, and improved risk assessment. Team diversity in healthcare "facilitates friction that enhances deliberation and upends conformity," resulting in better decisions and improved financial performance, consistent with evidence from the non-healthcare arena.[22] Increased gender diversity on teams is directly associated with more cooperative behavior; male physicians who have more exposure to female physician colleagues are better able to treat female patients.[23]

We see a connection between collaboration across diversity and increasing impact of scientific work, and, in one study, ethnic diversity was found to have the strongest correlation with scientific impact.[24] All this can lead to better science, better patient care, better population outcomes, and more impactful healthcare systems.

Finally, evidence from outside medicine indicates that diversity on teams is good for business. Diversity on teams allows companies to outperform their competitors, helps leadership teams overcome adversity, and flourish by improving their decision making, elevating creativity and innovation, and significantly improving financial performance.[25,26,27]

Terminology

Clarity of terminology is important when discussing aspirational change. As the research and potential solutions to our diversity, equity, and inclusion challenges in medicine are discussed in the documents in this report, we will use these words with specific meanings in mind. The concepts described by these words can be easily misunderstood, so developing a common language will improve communication with readers and allow for an evolution in thinking.

Diversity is often thought to represent gender and race, but in reality, is broader than identity alone. The concept of diversity is better thought of as bringing together people with diverse identities and ways of thinking to broaden the "cognitive repertoire" (scholar Scott Page). These people bring diversity of thought, providing increased capacity and power for tasks and teams. Grouping people of diverse perspectives and skills to work together creates opportunities for more problem-solving and creativity, as well as better recognition of possibilities and risks.

Inclusion is a complementary and essential partner to diversity because it creates a culture in which every individual's contribution is valued and heard. If the culture is inclusive, the team respects each member, and each member feels safe and valued when contributing. Interacting in a constructive and productive way, the inclusive team is able to benefit from diversity.

Equity involves intentional, consistent, culture-building efforts to optimize the organization's understanding and handling of the lifetime of implicit bias faced by people from diverse groups. The goal is to provide access and opportunities to every member of the team. Thoughtful leadership and systems change are often necessary to mitigate implicit bias and approach or achieve equity.[28]

The term clinician is used to be inclusive of both physicians and physician assistants. The OMA is composed of both physician and physician assistant members. When other terms are used, it is to more accurately reflect the scope of a specific study and is not meant to exclude either type of training or professional affiliation.

Pathways into the Medical Profession

For underrepresented minorities, including African Americans/Blacks, Mexican Americans, Native Americans (American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans, the barriers to entry into the health professions begin long before professional training. These groups comprise approximately 41 percent of the United States population but represent only 12.9 percent of practicing physicians[1] and 13.3 percent of practicing physician assistants.[29]

When compared to US census data, African Americans/Blacks, American Indians/Alaskan Natives, and Native Hawaiians/Pacific Islanders have less representation in the medical school population than expected, while Asian medical students are represented higher than expected.[30] This is predominantly explained by the fact that members of these racial groups remain underrepresented among medical school applicants and matriculants.[10]

According to data collected by the AAMC, from 2013-2018, the rates of graduation from medical school for American Indians/Alaskan Natives remained at 0.2 percent of women and increased from 0.1 to 0.2 percent of men. Native Hawaiians/Pacific Islanders remained at less than 0.1 percent of medical school graduates. Hispanics, Latinos, and those of Spanish origin dropped from 5.6 to 5.4 percent of women graduates and increased from 4.7 to 5.3 percent of men graduating from medical school during this time period.[1]

While already significantly represented, Asian students made additional gains from 21.5 to 22.7 percent of women graduating and from 19.8 to 20.6 percent of men graduating from medical school. The representation of African Americans/Blacks increased slightly from 7.8 to 8.0 percent for women, and 3.9 to 4.6 percent for men during those years.[31] However. It is important to note the overall downward trend for African American/Black men from 1986 to present.[32,33]

Women, overall, have actually surpassed parity with men in the number of applications to medical school.[1] This is poorly reflected in the appearance of the profession beyond medical school because of the impediments to career advancement women encounter beyond graduation.

In the Physician Assistant Education Association program survey, published annually, students are categorized as “male,” “female,” or “unknown gender.”[34] According to the 2019 report, 72.2 percent were female, 26.4 percent were male, and 1.3 percent unknown. It should be noted that the report does not feature an option to include data on students who are non-binary. 7.6 percent of students identified as “Hispanic, Latino or Spanish in origin,” 0.5 percent identified as “American Indian or Alaskan Native,” 9.9 percent as “Asian,” 3.9 percent as “Black or African American,” 2.2 percent as “multiracial,” 1.6 percent as “Native Hawaiian or Pacific Islander,” and 69.4 percent as “White.”

In 2009, the WHO recommended increasing workforce diversity to address social accountability within healthcare and to alleviate health inequity.[35] Numerous studies demonstrate that increased representation of UriM improves the health of patients and communities. Racially and ethnically concordant patient-physician relationships lead to a greater degree of trust, patient satisfaction, equitable care, and better health outcomes for disadvantaged populations. The lack of diversity in the medical profession is seen as a major contributor to the disparately poor health outcomes seen in people of color in the United States.[36,37,38,39] To correct the

underrepresentation of minorities in the health professions, interventions must be applied early in the pathway.

The extent of disparity varies by specialty. In one longitudinal study of 16 specialties, Black and Hispanic/Latinx physicians showed a significant trend toward reduced representation in most specialties from 1990-2016. The only notable exception was Black women physicians in academic obstetrics/gynecology.[40]

The number of African American physicians in the United States continues to be unrepresentative of the US general population. The current system is inadequate in generating a workforce that represents the diversity of the United States. Only 10.8 percent of all practicing physicians are Black/African American or Hispanic, and they are not evenly distributed among specialties.[1] A number of specialties report a general lack of diversity, including radiology, oncology, emergency medicine, orthopedic surgery, obstetrics and gynecology, and ophthalmology.[12,41,42,43,44,45,46,47] Among physicians in primary care, underrepresented groups (Black, Hispanic, and Native Americans) together constitute 13.4 percent of practicing physicians. Nonetheless, the diversity of these primary care physicians does not reflect the population diversity of the nation, where these groups represent a much larger fraction of the overall US population (30.5 percent).[11]

According to the American Academy of Physician Assistants (AAPA) demographic data on active Pas, the profession is predominantly white (88.5 percent). Only 2.7 percent of Pas identify as Black/African American, 3.4 percent as Hispanic/Latino, and 3.9 percent as Asian.[48] However, it is important to recognize that many organizations, including the AAPA, only collect data on active members within the organization. As a result, statistics on minority individuals within the profession as a whole are often not accurate. The certifying body, NCCPA, has reported the profession to include 86.7 percent white, 3.6 percent Black/African American, 6 percent Asian, 0.3 percent Native Hawaiian/Pacific Islander, and 0.4 percent American Indian/Alaska Native.[29]

In this section, we will describe some of the many issues that impact progress in this area. The resistance to progress is primarily an issue of the American structural culture that has permeated healthcare. The paucity of UriM clinicians entering the profession and advancing cannot be attributed to a lack of talented members of these communities. Educational, social, structural, and cultural barriers woven into the fabric of this country significantly limit opportunities and constrain pathways to higher institutions of learning for nontraditional students.

At the end of the pathway, these students face the existing culture, social mores, and norms of academic health centers, which have endured for over 300 years and were originally established by predominantly white, upper-middle class Northern Euro-American heterosexual men, for the benefit of none other than the same. These continue to pose a barrier to those falling outside this antiquated standard for the profession. Those who live at the intersection of multiple nontraditional identity characteristics face even greater challenges. Change to this system, which stands as the pathway and portal to entry into the medical profession, has been very slow and is unlikely to be more than incremental without intentional and targeted action.

To address the urgent need for a diverse health profession workforce, the barriers to entry for UriM must in turn be identified and addressed. For underrepresented minority students, barriers exist at various time points in the pathway that prevent these groups from entering the

profession and achieving their goals. These barriers start early in their educational process and continue until late in their careers. Disparities in K-12 education, increasing tuition, lower acceptance rates, and social isolation have all been shown to serve as barriers for underrepresented minorities attempting to enter the health professions.

The lack of diversity in the health professions is, in major part, a reflection of our nation's unresolved issues, with race and racism resulting in fundamental social inequities. These inequities are reflected within our public-school systems and result in unequal opportunity and access to knowledge for minorities. Bias-influenced practices lead to sorting and stratifying of UriM students by race and ethnicity and not by intellectual potential, motivation, and effort.[49] These practices disproportionately exclude UriM students physically from advanced academic classrooms and psychologically from believing they are meant to participate fully in academic institutions. Biases may also influence teachers to have lower expectations for minority students in comparison to their white peers.[50]

The implicit and explicit bias experienced by UriM students can affect their attitudes toward learning in general. Black and Latinx students are consistently punished more severely than white students for the same infractions.[51] Students of color are disproportionately disciplined in schools. African American/Black students are nearly four times as likely to be suspended from school as are white students, nearly three times as likely to be removed from class but kept in school, and almost three times more likely to be expelled. They are also about three times more likely to be referred to the police for an incident on school grounds and 3.5 times more likely to be arrested for an incident on school grounds during school activities.

Such disciplinary actions are associated with a spectrum of negative life outcomes, including involvement with the criminal justice system. A Princeton University study found a direct relationship between the level of implicit and explicit bias in a community and the level of bias in the schools of that community with respect to discipline. This was true across the United States.[52] According to a 2014 report by the US Department of Education's Civil Rights Office, there are widespread disparities in how schoolchildren are punished, such that Black and Latinx students are punished more severely for the same infractions.[53] Zero-tolerance policies appear to be responsible, but the policies are clearly discretionary in their application, with a bias favoring white children.[49]

Impact of Educational Factors

The barriers that exist for UriM students at the kindergarten level through 12th grade include limited resources in public schools in lower socioeconomic neighborhoods, limited exposure to STEM programs and health careers, poor advising, and bias from teachers and other staff.[54]

To increase the possibility of success for minority high school students interested in a career in the health professions, individualized guidance and exposure to health professions and minority health professionals is critical. These factors can impress upon a student that they are capable and that they have a place in the institution of medicine. Exposure, access to knowledge, mentorship, and appropriate guidance are necessary to broaden and smooth the pathway from kindergarten to a medical profession.[55,56]

On-campus enrichment programs such as OnTrack OHSU and Summer Internships provide K-12 students with early exposure to healthcare professions. These programs have been identified as one of the most effective recruitment strategies for recruiting UriM students to graduate PA school.[57]

Barriers at the Elementary School Level

Academic disparities are apparent as early as kindergarten. Black and Hispanic children are more likely to live in poverty,[58] a condition that research suggests is associated with lower than average academic performance that begins in kindergarten[59] and extends through high school, leading to lower than average rates of school completion.[60] Efforts to achieve racial and ethnic diversity in the healthcare profession must begin early and be sustained from the preschool through secondary school levels. Given the progressive nature of education, the earlier interventions begin, the more likely they are to be effective.[61]

Well-designed early childhood interventions programs have demonstrated benefits in a wide range of areas, including academic achievement, behavior, educational progression and attainment, delinquency and crime, and labor market success. The results, although not uniform, are improved by better-trained caregivers and smaller child-to-staff ratios. The return on investment to society ranges from $1.80 to $17.07 for each dollar spent on the program.[61] Beyond improving education overall in communities of color, generating interest in the medical field represents an additional challenge.[61] Racial and ethnic minorities in the United States tend to live in lower socioeconomic neighborhoods. Since public schools are most often predominantly funded locally, lower socioeconomic districts generally do not have the resources to attract and retain strong, engaged teachers or fund STEM labs.[62] Poorly-equipped schools with limited resources are unlikely to yield large numbers of medical school candidates. Students from such schools historically underperform their peers who have access to better resources. This dearth of resources contributes to lacks in other areas, namely adequate science knowledge, interest in science, health career options, correct information about academic requirements, access to technology, and effective study skills. There is strong evidence that programs designed to recruit and prepare UriM students for careers in the health professions improve students' academic achievements, including improved grades, likelihood of high school graduation, SAT scores, and college entry.[32]

Barriers at the Middle and High School Levels

Teachers' belief or confidence in their students' academic skills and potential is "a vital ingredient for student success" because it is linked to students' beliefs concerning "how far they will progress in school, their attitudes toward school, and their academic achievement."[63,64] Student attitudes about education and its potential in their lives have a significant impact on their self-efficacy, which in turn impacts student academic performance and career aspiration.

Studies have demonstrated significantly higher high school dropout rates for UriM students. One such study published in 2004 showed that more than one in five Latino students and one in ten African American/Black students have dropped out of high school, while the incidence of dropout for white students is only one in seventeen.[65] More recent data from the US Department of Education National Center for Education Statistics have shown improvements in these trends, namely: "From 2000 to 2016, the Hispanic status dropout rate among 16 to 24 year-olds decreased from 28 to 9 percent, while the Black rate decreased from 13 to 6 percent, and the White rate decreased from 7 to 5 percent. Nevertheless, the Hispanic status dropout rate in 2016 remained higher than the Black and White rates."[62]

Although members of the Hispanic community are generally considered together for statistical purposes, there are significant differences in their experiences based on country of descent. According to the US Department of Education, in 2016, among Hispanic 16 to 24-year-olds in the United States, the high school status dropout rate ranged from 2.4 percent for individuals of Peruvian descent to 22.9 percent for those of Guatemalan descent. Similarly, among Asian 16

to 24-year-olds, dropout rates ranged from 0.7 percent for individuals of Korean descent to 29.7 percent for those of Burmese descent.[62]

Although the trend is improving, the loss of UriM students at the high school level continues to contribute to the limited pool of UriM students in institutions of higher learning, significantly limiting the pool of potential future UriM health professionals.[65]
The impact of guidance counselors and teachers is even more significant and can be less readily corrected due to the compounding effects of the aforementioned barriers. Advice or guidance from school counselors and teachers often differentially nurtures the potential of students on the basis of race and ethnicity, to the detriment of UriM pupils.
Similarly, reduced expectations from teachers can lead to what President George W. Bush described as "the soft bigotry of low expectations."[66] When a teacher underestimates a student, it affects not only that one student-teacher relationship, but also the student's entire self-concept, as well as more tangible measures like their GPA. In fact, the 2002 Education Longitudinal Study found that "Teacher expectations were more predictive of college success than most major factors, including student motivation and student effort."[67]

LGBTQ+ students face similar early discrimination in K-12 education where, especially in high school, social interactions and sexuality become important to identity formation and the ability to "fit in." Discrimination and marginalization impact students' ability to succeed academically by denying them an environment in which they feel supported and affirmed.[68] State and local K-12 education policies with clear language regarding protection of LGBTQ+ students from bullying and discrimination are associated with positive school climates and with student wellbeing and success.[69]

Like racial minority students, LGBTQ+ students have fewer role models in the workforce and perceive less support and guidance compared with their heterosexual peers, which can negatively impact their choice of vocation. The experience of discrimination and bias in the college environment can also influence professional identity and career development.[70] There are limited data on this issue, in part because disclosure of diverse sexual orientations or genders can lead to retaliation and harm.

Challenges Outside the Classroom

Children of low-income families experience challenges that extend far beyond the classroom, and poverty impacts African American and Latinx families disproportionately. Since 1966, Coleman and others have concluded that the socioeconomic status of families is more important than schools as a factor for academic achievement and this is not unique to the United States.[58,71,72] Reardon has compiled data showing that student test score differences related more strongly and negatively to poverty than any differences associated with race.[73]

Residents in low-socioeconomic neighborhoods are disproportionately exposed to various hazards, including increased noise levels from traffic and freeways[74,75] or environmental toxins in water (as in Flint, Michigan),[76] air,[77,78] and ground (from landfills or toxic waste treatment facilities.[79] Lead poisoning disproportionately impacts children of color.[80] Exposure to violence, domestic, community, or through public media, is statistically more likely in communities of color.[81,82]

These factors not only contribute to health disparities in the US but can have direct or indirect effects on the abilities of children to perform well in school. Other factors suggested to affect

children's learning include the physical environment at school and nutrition, both of which can be negatively impacted by segregation and poverty.[83]

Social "inequities are related to elevated stress in families from many factors including (a) being unable to meet basic financial obligations for food and shelter, (b) living in high risk neighborhoods with elevated levels of violence and depressed levels of social capital, and (c) not having the means to provide educational and social opportunities to enrich children's development, which may involve placing children in high quality child care, public or private schools, and affording selective or elite colleges and universities."[84]

As the socioeconomic divide continues to increase, it is important to acknowledge the impact on UriM students of lower socioeconomic status. Reducing educational disparities may be a critical component of reducing other kinds of inequities in the United States.[85]

With the multiplicity of impediments and adversity these students face, their resiliency in merely showing up in the classroom deserves to be acknowledged. The ones who succeed despite all these disadvantages often do so at an additional price. They accomplish their goals with limited resources, but with ingenuity and drive.

Early exposure and mentoring enables members of underrepresented groups to see a medical profession as an accessible career option, especially exposure to or interaction with ethnically concordant mentors.[86] However, due to the paucity of UriM healthcare professionals in the community and general lack of access to health professionals, envisioning these careers as an option continues to be a challenge for UriM students.

Barriers in Undergraduate Education

As previously mentioned, a student's experience in school is vital as they develop their interests and gain support in entering career pathways. Students who feel at risk of "stereotype threat" experience lower academic performance.[87] Due to this phenomenon, one study implemented an affirmation intervention to groups of students in an introductory biology class. The students were asked to make connections between positive values to themselves. The researchers discovered that the affirmation benefited UriM students and white males in their performance with a 4.2 percent increase in male UriM students on average and 2.2 percent increase in female UriM students on average. While the author points out potential limitations, this study indicates that the environment and psychological support can reduce barriers to success in STEM and facilitate retention through breaking the stereotype threat.[87]

Perceived bias also exists among UriM students. Tour of Diversity in Medicine, a program consisting of minority physicians and dentists, visited colleges in 2012 and 2013 and held focus groups to examine barriers in the undergraduate setting that hindered entry to advanced healthcare training, specifically careers in medicine and dentistry. Among the 82 participants from 11 colleges, challenges such as inadequate clinical opportunities, family pressure, and inadequate guidance and mentoring on career development all factored into the decision to remain in the pathway to a medical or dental career.[88]

In addition, UriMs are more likely to switch from a science major to a non-science major. In interviews with 27 African Americans and 22 Latino Americans, a study identified four common themes among engineering majors. These themes included alienation and invisibility, lack of racial concordance in peers and faculty, difficulty applying theory, and lack of college

preparation.[89] This study further supports the need for early intervention in the pathway process to support underrepresented minorities on the path toward a STEM career.

Historically, rubrics for admission to medical and PA programs have prioritized success in foundational sciences and top standardized exam scores. Use of the MCAT for admission decisions may disadvantage some capable students, and this test has not been shown to be a better predictor of success in medical school than prior academic achievement.[90] However, success in undergraduate sciences and standardized test-taking are influenced by social and economic factors. Emphasis on these criteria alone may be a barrier to diverse applicants who demonstrate behaviors and characters that are essential to success as a clinician.[91,92] Holistic admissions can help capture capable students who will bring strong academic and personal qualifications to their work.[90]

Incorporation of a holistic admissions process is an important area for consideration of a diverse applicant pool. Holistic admissions processes give consideration to each candidate as an individual and account for factors that are correlated to success as a clinician. A candidate's relevant life experience such as accomplishments (volunteering, leadership, employment, shadowing), academics (GPA exam scores), disadvantaged status (first generation, geographic location, economic status), and ability to manage significant adversities encountered along their journey towards medical training (educational, family, cultural) are reviewed. The process is applied equitably across the applicant pool at the time of admission application reviews and throughout the entire admissions process. Holistic admission processes have demonstrated success in diversifying medical cohorts. A more diverse student body not only better reflects the diversity of the general population; these cohorts have also been observed to be more collaborative, supportive, and open to new perspectives.[91]

In addition to assessing the admission process and providing holistic reviews of candidates, we must also recognize and address the presence of implicit biases, whether intentional or unintentional, that may contribute to the persistence of underrepresentation in medical education. A study at Ohio State University College of Medicine (OSUCOM) in 2012 reported that, collectively within the admission committee, there existed implicit white preference after taking the Black-white implicit association test. This introspection fostered more self-awareness that led to the most diverse class in the OSUCOM history in the following interviewing cycle.[93] With the increase in application competitiveness, it is important to implement holistic reviews and assess soft skills, especially if underrepresented applicants had above-mentioned barriers to access pre-medical opportunities that could strengthen their applications.

Due to the competitive nature of medical school admission, many students who are not admitted in an application cycle often take a gap year to strengthen their applications through various avenues. One of these is attending a post-baccalaureate program to increase the student's grade point average and to better demonstrate readiness for intense science courses. A study with 516 participants from one medical school showed that 15 UriM had completed a formal post-baccalaureate program, while 58 students had independent post-baccalaureate work before matriculation. Of the 73 students in the study, those that completed a post-baccalaureate program showed competency in the first year of medical school as compared to their traditional student counterparts, despite having lower MCAT scores and college grade point averages.

This indicates a post-baccalaureate program may represent an appropriate preparation for success in medical school.[94] In a 2016 publication, about one third of the 200 postbaccalaureate premedical programs in the AAMC website were listed as having special focus on UriM for

economically or educationally disadvantaged students in efforts to close the gap in healthcare disparity.[95] As previously mentioned, many students who identify as UriM also associate with hailing from low socioeconomic backgrounds. This financial burden may present as an additional barrier to attending a post-baccalaureate program, retaking standardized tests, or reapplying to professional healthcare programs.

Representation in Medical School

Minority physicians face many barriers contributing to reduced representation in medical training programs. While attempts such as affirmative action on higher education have created conversations on diversifying medicine through admission, progress has been slow and the rate of increase in graduates from this underrepresented group remains low.[33,96] Expansion of medical schools changed minority student numbers little, although new schools did enroll more racial/ethnic minorities and lower socioeconomic students.[97] From 2015 to 2019, there was just a one percent increase in the number of African American medical school graduates in the United States.[98] Despite a very gradual increase in the number of Black college graduates over time, there were fewer Black men entering medical school in 2014 than in 1978.[33]

There are historical reasons for the lack of diversity in healthcare professions. Historically Black medical schools have faced inadequate funding and access to facilities compared to historically white institutions.[99] In addition, changes in medical school curriculum have created downstream consequences in the overall diversity of the healthcare workforce. The 1910 Flexner Report examined medical school entrance requirements, the size and training quality of facilities, the size of endowment and tuition, the size of laboratories, and the availability of teaching hospitals and their clinical teaching staff in order to standardize admission requirements and design medical school curricula to include both basic science and clinical exposure.[99]

As a result of this report and subsequent changes in medical programs, 13 of the 17 historically Black medical schools were closed.[96] A recent economic impact analysis shows that if only five of these 13 closed schools had remained opened, an additional 27,773 Black doctors would have graduated from the year of closure to 2019, if each program had maintained steady expansion.[96] Complicating interest in recruiting a more diverse group of students to medical school is the declining racial and ethnic representation in academic medicine.[40]

Trends in medical schools are mirrored by poor diversity in the PA profession and difficulty increasing diversity.[46] PA programs in general have greater proportions of women than men among both the faculty and students (61.3 and 72.9 percent, respectively), making women PA students and faculty overrepresented when compared with the US population.[100]

Nonwhite PA students encounter numerous challenges during PA school, measured by the number who delay their graduation. 94.3 percent of students who identify as female and 91.5 percent who identify as male graduated or expect to graduate on time. 91.6 percent of Hispanic, Latino, or Spanish-origin students, 90.6 percent of American Indian or Alaskan Native students, 92 percent of Asian students, 81.2 percent of Black or African American students, 95 percent of multiracial student, 97.9 percent of Native Hawaiian or Pacific Islander students, and 94.6 percent of white students graduated or expect to graduate on time.[100] A delay in graduation can increase the cost of tuition and delay time to entering the job market and earning a salary. Potentially, this could also cause attrition.

We have limited information about the LGBTQ+ community and how clinicians and physicians are impacted by this perceived difference.[101] There is some evidence that this group also faces

barriers from the start of medical education. There are approximately 3.5 percent, or 9 million, adults in the United States who identify as lesbian, gay, or bisexual, and 0.3 percent, or 700,000, as transgender, according to a 2017 study.[21] Data on the degree to which these groups are represented in the medical profession in the literature at the time of this report were very limited.

A medical school survey directed at all medical students in the US and Canada during the 2009-10 academic year showed that approximately 30 percent of LGBTQ+ students conceal their sexual orientation identities in medical school. Approximately 40 percent were afraid of discrimination when identified as non-heterosexual.[102] While there are no large-scale studies on representation among resident physicians, practicing physicians or physician leaders, the AAMC now tracks the percentage of graduating medical students who identify as bisexual (~5 percent) gay or lesbian (3.8 percent) and transgender (0.7 percent), with the most recent data from 2019.[103]

Barriers to Success in Medical School

Apart from the application process, the monetary costs of health profession education are another significant barrier to entering the field, regardless of the UriM pathway. Underrepresented minorities, more often than not, come from an economically disadvantaged background, which requires them to take out more loans or scholarships. However, barriers such as financial credits to apply for loans and the necessity of a good academic standing to apply for scholarships could further inhibit students from receiving support.[104] A report from UCSF shows that the amount of debt carried on average is larger for UriM than white matriculants to US medical schools. In 2015, 35.8 percent of white matriculants had student debt prior to medical school, while American Indians, Latinos, and African Americans were 46.2, 46.3, and 62.1 percent, respectively.[105]

Outside of the rising cost of tuition for medical school, an entire industry has been built around preparation for national board examinations that are required for advancement and graduation. Examination scores can further bar students from entry into specialty programs; however, USMLE scores do not correlate with success on medical rotations or within residency programs.[106] The USMLE Step 1 exam has received recent attention for the inequities seen in exam scores. People of Color, namely Black persons, score lower on-board examinations than their peers.[106]

In addition, women have been found to score lower than their male counterparts.[107] Despite significant differences found in standardized test scores, a student's USMLE score was not predictive of student success in the clinic. Data on Hispanic Latino and Native American students are lacking and are a future area for research. From multiple studies, it is apparent that Step 1 score has little predictive value in identifying future success in residency programs. Compared to Step 1, the Step 2 CK exam is a stronger predictor to residency success and in-training examinations, along with emphasis on honors in clerkship and membership in the Alpha Omega Alpha Honor Society.[106,107,108]

Other factors aside from standardized score performance also affect the success of students during medical training, specifically for UriMs. Overall, traditional-aged students who are less than 25 years of age at matriculation performed better on Step 1 and Step 2 than did non-traditional-aged students. Male students performed better on Step 1 than did females, per a longitudinal study across five graduating classes at the University of Minnesota Medical School.[108]

However, a different study shows that women were more likely to pass Step 2CK on the first attempt, indicating that women improve during clinical years.[95] This study also demonstrated that older students greater than 24 years of age who initially failed Step 1 were less likely to pass Step 2 CK on their first attempt.[95] Financial barriers also play a role in student success on national board exams, with differences in Step 1 scores seen between those who received need-based financial scholarships versus those who did not receive scholarships. This could potentially be explained by these students' inability to access supplemental materials or exam preparatory courses prior to medical school. However, more studies are needed to explore the correlation.[107]

In addition, the passing rate for Step 1 on the first attempt also differed by race and ethnicity: 93.4 percent for white, 86.8 percent for Asian, 77.5 percent for Hispanic, and 58.2 percent for African American.[95] Each residency program and specialty has a different score threshold for residency applicants. African American applicants were 3 to 6 times less likely to be offered an interview at internal medicine residency programs compared to the non-African American counterparts if the Step 1 score was used as the primary determining factor for granting interviews.[106]

Success in medical school can also be affected by inclusion in honor societies and biased evaluations. Underrepresented minorities are less likely to be nominated to the Alpha Omega Alpha Honor Society (AOA) in medical schools, possibly reflecting bias in selection.[109] Odds of AOA membership for white students was six times greater than for Black students and two times greater than for Asians, although no significant differences are found in median time dedicated to leadership activities and community service between AOA and non-AOA students.[109]

Students in minority groups report racism and prejudice during their education and continuing throughout their professional careers.[20] Discrimination between clinicians as well as from institutions is cited. The higher rates of mistreatment experienced by female, UriM, Asian, multiracial, and LGBTQ+ students, as discussed in the Workplace Culture document of this report, further impact grading and written evaluations.[110] Prejudice and bias can discourage career advancement in the workplace, contributing to disparities further discussed in the Workplace Culture and Pay sections.[111]

Initiatives to improve diversity in the health professions will require analysis, and possibly intervention at every level of pathway process. We conceive of this first as bringing a diverse population of candidates to the doors of the schools that train physician assistants, medical doctors, and osteopathic doctors.

Beyond this, the schools themselves should not present an environment hostile to diversity, because enabling the ultimate transition of this polychromatic group of students into the medical profession should be considered as being in the best interest of the future of healthcare in the United States. Once these members have enriched our ranks, their talents and voices must be heard and should influence decisions affecting care teams and our systems of care. Short of this, we would be losing the benefits diversity can provide.

Workforce Culture

Workplace culture can be defined as a construct that is “the sum of jointly held characteristics, values, thinking and behaviors of people in workplaces or organizations.” This can be shortened to “the way we do things around here.”[112] This can be influenced by both the larger organizational culture that is present at the hospital or health system level and the unique workplace culture that exists at the unit, department, or healthcare professional level.[113] Though culture can be changed, there is an enduring and historical aspect to it.

Workplace or organizational climate is more narrowly defined as the emotive feel as people interact with the culture and each other and also includes their behaviors in response. It is thought to include relationships and attitudes, engendered through interactions with organizational structures and processes.[114] Essentially, workplace climate consists of people psychologically reacting to their work environment, i.e. “How does it feel to work here?”

Perceived tolerance of harassment, microaggressions, discrimination and/or violence based on gender, race, ethnicity and/or sexual orientation—usually in environments where men outnumber women and whites outnumber people of color—as well as protectionism and uninformed leadership within institutions all work to create an organizational climate that negatively impacts the workforce.[115,116,117,118]

In medicine, hierarchical relationships create a power structure that persists in all levels, from training through to the workplace despite proven negative effects on patient care and patient safety, as well as professional wellbeing and development. These further strains the culture within medical institutions.[119,120]

Without a culture of inclusion that can give voice, leverage, and fair access for promotion to new arrivals, retention of new clinicians may be at risk. Turnover is estimated to cost the healthcare system between $400,000 and $600,000 per physician.[121] Retention saves the healthcare industry money.

Discriminatory culture of a workplace environment is the primary factor impacting turnover of physicians from underrepresented groups.[122,123] Systemic racism has helped shape the current norms for workforce culture and furthers the inequities seen in the workforce and healthcare system.

The health of a workforce culture can be measured in part by how individuals perceive the institution, trust leadership, and enjoy institutional support with robust resources designed to support underrepresented people in medicine. A positive healthcare workplace culture has been associated with a wide range of improved patient care outcomes, including lower mortality, lower rate of adverse events and medication errors, lower rate of hospital-acquired infection, patient satisfaction, and many others.[113] Strong team culture has also been associated with lower burnout among clinicians in the primary care setting.[124] However, while the benefits of a positive workplace culture are numerous, the experience of workplace culture varies among groups, with racial, ethnic, and sexual minority groups and women often experiencing negative workplace cultures in medicine due to their identities.

Discrimination

UriM residents experience discrimination frequently as microaggressions on the basis of race, ethnicity, and perceived status as “other” or foreign.[116] This is true for attending physicians as

well, and may contribute to lower career satisfaction, turnover, and avoiding seeking leadership positions.[122]

Physicians of color, especially Black physicians and women physicians of color, experience a high prevalence of workplace discrimination.[123] This discrimination was associated with adverse effects on career, health, and work environment. Critical to retention of these clinicians is the workplace environment. Institutions must work to create welcoming workplace environments that do not serve as additional cultural barriers in the long line of impediments UriM individuals face throughout their pathways into medicine. This includes identifying and changing policies that disproportionately and adversely affect certain groups in medicine based on race, ethnicity, gender, or sexual orientation.

Gender-based discrimination is also alarmingly common in medical practice and academic medicine. A study that sampled over 3,000 full-time faculty found that women were 2.5 times more likely than male faculty to perceive gender-based discrimination at work.[125] Women also experience stigma and discrimination due to decisions around pregnancy and family, contributing to work-family conflict and ultimately to burnout.[126]
Aside from race and gender issues, sexual orientation and gender identity adds another layer of difficulty to navigating a career in medicine and poses an increased risk of discrimination and harassment. A 2014 study reports that among the LGBTQ+ healthcare professionals and trainees, 41.9 percent of study participants avoided disclosing their sexual orientation due to fear of negative consequences: harassment or discrimination. Some individuals report being refused privileges, being denied promotions or employment, and/or experiencing verbal harassment from colleagues.[127]

More research is needed to understand the workplace experience of clinicians who are transgender, gender nonconforming, lesbian, gay, or bisexual. One study has found that although overall rates of discriminatory behaviors are decreasing, micro and overt aggressions including derogatory comments about the LGBTQ+ community in general, refusal to write letters of recommendation, and overt harassment are still commonly experienced and observed.[118,128]

Furthermore, a 2017 study of transgender and non-binary physicians and medical students found that 42.9 percent of respondents reported facing barriers due to their gender status in applying to residency/fellowship and 69.4 percent had witnessed negative comments about transgender and/or non-binary individuals in their training or practice.[129] While the Supreme Court of the United States has ruled it is prohibited to discriminate based on sexual orientation and gender identity in the workplace, workplace cultures still need to shift to eliminate discrimination and retain these clinicians.[130]

The intersectionality of race and gender compounds all these challenges and worsens the effects of discrimination and systemic inequities related to compensation and career advancement.[116] Increasing institutional support for UriM, women, and LGBTQ+ people, as well as robust processes for reporting, may help retention of members of these groups.[114,116,131] Fundamentally, organizations must fully integrate and center diversity as part of the overall mission to increase institutional commitment and reduce discrimination.[131]

Sexual Violence

Sexual violence includes harassment, unwanted sexual attention, non-consensual acts, and sexual coercion. Sexual violence is power based, sustained over time, and function as methods to assert power, control, or intimidation over other people. Workforce culture, power dynamics,

and hierarchies all allow the perpetuation of sexual violence in medicine. Gender-based harassment and macroaggressions can originate from peers, supervisors, and patients.[132] False reports are rare, illegal, and occur at a lower rate for sexual violence than they do for all other major crimes.[133]

In 2018, the National Academies of Sciences, Engineering, and Medicine[115] released a report on sexual harassment of women in academia.[115] The report shows that medicine as a profession has a culture of harassment and assault driven by organizational climate.[115] The research found that students and trainees in science, technology, engineering, and mathematics (STEM) are 96 percent more likely than non-STEM majors to experience sexual harassment by peers.

When compared with students in other fields, women medical students were more likely to experience sexual harassment by faculty. In graduate medical education, 45 to 50 percent of female-identifying medical students reported gender harassment or sexist hostility by faculty or staff. Students are also frequently harassed by their peers.[134,135,136,137,138] An American Association of University Women study found that 80 percent of harassed students reported that the183rganient came from peers or former peers.[134] The peer-to-peer violence data for medical training are lacking and represent an area for future research.

Women are also frequently harassed by coworkers and other employees.[134,135,136,137,138] The hierarchical nature and predominantly male leadership within the field of medicine creates a power differential that enables sexual harassment. Additionally, in the medical field, patients are also potential perpetrators of sexual violence. One study found that more than 25 percent of male and female surveyed physicians experienced at least one incident of sexual harassment from patients.[139] In addition, the assumption some patients make that female clinicians are non-physician members of the support team may impact patient care by eroding the patient-clinician trust relationship.

The experiences and numbers of LGBTQ+ medical clinicians continue to be understudied. The few studies that exist indicate these individuals experience and expect harassment and may conceal their sexual orientation as a result.[140,141]

The impacts of sexual violence are long-lasting. Survivors face worse mental health and physical outcomes, feel less safe on campus, and report doing poor work more often.[141] Barriers to reporting sexual violence include fears of retaliation, physical harm, or not being believed.[142] The fear of retaliation is a major barrier to reporting and ultimately to addressing and preventing sexual violence within medical institutions. The NASEM report found that 28 percent of medical students did not report incidents of offensive comments due to fears of retaliation.[115] Retaliation can have long-lasting impacts on career trajectory for an individual, and the inability to report or seek resources without fear of retaliation allows continued harms and prevents progress toward a violence-free workplace. This may also further contribute to burnout experienced by healthcare clinicians.

Institutional betrayal is defined as “wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings by individuals.”[143] When institutional betrayal occurs, both pragmatic and psychological harm to an individual can occur.[143] This concept has been demonstrated in recent history by the response or lack of action in regards to sexual assault. Increased research, training,

transparency, and support services are necessary to best address gender-based violence in medicine.

The time and monetary burden placed on survivors to pursue civil, criminal, or institutional reporting pathways, as well as outside resources for support and advocacy, are additional barriers to reporting violence. The perception of a risk to career and that reporting will result in no shift in culture also negatively impact the likelihood of reports being made.[144] Confidential advocates are a vital resource for supporting survivors of sexual violence.[145] Advocates can help survivors navigate civil, criminal, and institutional reporting pathways, provide and connect survivors to resources, facilitate academic support, formulate safety plans, and help work to prevent sexual violence in the institutions they serve. These experts should be sought out for guidance in institutional policies and fully funded in medical institutions to support survivors who work in medicine.

Harassment

Harassment in the workplace results in lower career satisfaction and higher levels of burnout.[132,146] Many female clinicians, clinicians from UriM backgrounds, and clinicians who identify as gender minorities report harassment and workplace bias as factors that contribute to their decision to leave their practice or exit the medical profession altogether.[147]

Minority Tax

A disproportionate burden is placed on UriM faculty in medical education. Women of color in medicine experience even greater barriers to advancement or attainment of leadership positions than do their white female counterparts.[148,149]

The responsibility for expanding diversity, decreasing racism, and mentoring, is sometimes referred to collectively as the “minority tax,” and falls disproportionately on UriM healthcare clinicians.[150] This may demand additional time and energy, as underrepresented minorities and women clinicians are often called upon to act as ambassadors, carrying out work related to diversity and inclusion for their respective institutions on top of the demands of their daily practices.[151]

Women in medicine readily volunteer for committee assignments, interviewing, and other uncompensated service tasks more often than do their male counterparts. These activities benefit their organization or practice, but they are not weighted equally with other activities when considering promotions. These additional tasks add to workload and can put clinicians at higher risk for burnout.[152]

This labor is generally not recognized in promotion portfolios and goes uncompensated. Because these individuals spend a disproportionate amount of time mentoring students, contributing to community outreach, and providing education on bias, there is less time to spend on research, publishing, or other scholarly activity commonly recognized as requirements for promotion and career advancement.

Representation and Mentorship

The lack of diversity in medicine has been a persistent problem, with little progress made over the past 30 years.[116,153] Proportional representation is an issue of access, mentorship, recruitment, discrimination, and many other factors. Many authors note social isolation and lack of mentorship to be significant challenges.[20,154] Many of these concerns are tied to the culture of medicine in an individual workplace and in the workforce as a whole. Workforce culture may be

one of the factors contributing to the lack of women and UriM clinicians in positions of leadership. The negative impacts of culture within a workforce are likely amplified when an individual belongs to multiple minority racial, gender, and sexual orientation groups.

LGBTQ+ individuals face unique challenges. To even quantify LGBTQ+ individuals in healthcare is a daunting task, as many see advantages in avoiding disclosure of their sexual orientation.[101] While workplace discrimination based on sexual orientation and gender identity is illegal, fear of discrimination in other aspects of an individual's life can serve as an impediment for LGBTQ+ people to live openly, let alone serve as role models and mentors for a new generation of clinicians. This suggests that proportional representation may be more difficult to achieve for this group, as potential entrants into the field will necessarily have fewer visible role models and mentors.[127]

Furthermore, the percentage of sexual gender minorities in each specialty is found to be inversely related to specialty prestige and positively correlated to perceived inclusivity.[155] Since sexual gender minorities are more likely to indicate the influence of choosing a specialty based on the culture around sexual and gender identity, it is imperative to foster an inclusive workplace to provide healthcare equity in all specialties.[155]

Generally speaking, women now enter the profession at the same rates as men; however, they still face barriers to advancement into leadership positions.[156] In the United States, women represent 51 percent of medical school applicants and 48 percent of graduates, illustrating that women and men enter medical practice at similar rates. Over the past decade, the proportion of women in full-time faculty positions has increased, and as of 2018, women constituted 41 percent of this workforce sector.[156]

However, the percentage of women in academic medicine decreases significantly with increase in promotional rank. According to the Association of American Medical Colleges (WII), only 18 percent of department chairs or deans in 2018 were women.[156] We can perceive the same imbalance with academic rank, with women representing 58 percent of instructors and only 25 percent of full professors.[156] More data are needed to illuminate inequitable representation on institutional C-suites and boards of directors throughout Oregon, as well as the resulting impact on diversity throughout the career pathway.

For people of each group and for people situated at the intersection of multiple groups, finding mentors to advise on career direction and advancement is difficult due to this underrepresentation, furthering this disparity. Specialized and long-term faculty development programs may result in an increase in recruitment and promotion, but it takes time for any program to have a measurable increase.[157,158] We must interrupt the cycle of underrepresentation leading to under-mentoring, which in turn leads to under-promotion, to improve the overall culture.

Paradoxically, without this change in culture, improving representation is challenging. Intersectionality must be prioritized in the creation and implementation of solutions when addressing workforce culture in medicine.

Career Advancement

The barriers faced in workplace culture may play a role in the maldistribution of underrepresented groups in many specialties.[12,41,42,43,44,46,47] In addition, underrepresented

groups in medicine face an additional complex set of challenges that pose barriers to advancement in the profession.

Barriers to career advancement based on gender has had more research. Women's disadvantages are present in the lack of parity in rank and leadership, as well as in retention and compensation. The factors that contribute to gender disparities are multifactorial, including expectations that women's careers will follow the same trajectory as men's without attention to the impact of the life cycle.[159] Women's academic productivity appears to peak later in their careers in terms of overall publication rates, although the publications they do have are noted to have higher impact based on citations rates. Lower early-career research productivity may contribute to women's difficulties with career advancement.[59,160]

Women clinicians who stay in practice are often overlooked when leadership opportunities arise. Few healthcare systems or practices have transparent, standardized processes in place to identify high-potential talent, resulting in biases when selecting a successor, often leaving women out.[161] Not only do women face challenges from outside forces, women clinicians are impacted by forces that appear on the surface to be internally imposed: imposter syndrome, limited skills at self-promotion, difficulty with salary negotiation, and limited flexibility to move or travel for career advancement. Imposter syndrome may be a reflection of the impact of cultural norms and gender expectations.[162]

Women's difficulties with negotiating are complex and may represent sensitivity to the social costs of negotiation. Female candidates are penalized more than male candidates for initiating negotiations in the workplace.[164,163]

Women may be overlooked in other ways as well, possibly representing bias in systems and among decision-makers. For example, women in some specialties have lower rates of NIH funding and may be less likely to attempt to renew research project grants.[141] Other studies cite differences in lab space, funding, personnel, and protected research time as vital to academic success.[165]

Women have been reported to be more likely to perceive inadequacy of access to human resources—specifically administrative and statistical support—and more likely to have requested a reduction in their clinical hours.[165] They have also been more likely to have raised with their superiors concerns about unfair treatment.[165] Women have fewer opportunities for prestigious speaker engagements and are underrepresented among recipients of recognition awards presented by medical societies, potentially impacting career advancement.[166,167,168]

Women face well-documented barriers to publishing, with limited representation of women on editorial boards of major journals.[169] Evaluations of women faculty and trainees show significant quantifiable linguistic differences, concerning for potential impact on promotion and retention.[170,171] A dearth of women on recruiting panels, leadership teams, and department oversight bodies results in magnification of bias in decision-making. Career advancement may also be impacted by caregiving responsibilities (as further outlined in the Caregiving section of this report).

Research on how career advancement is adversely impacted for other underrepresented groups in medicine is lacking. Of those entering academic careers at US medical schools, promotion rates for Black and Hispanic/Latino physicians were lower compared to white faculty.[9] Problems with career advancement has become a measurable parameter for women because of the

achievement of parity in numbers in the ranks. For UriM, parity is not even close to being achieved, as discussed elsewhere. When underrepresented minorities are more proportionately represented in the medical field, the issue of career advancement can be better studied.

Not only is an informed standard for promotion and opportunities essential, but the creation of equal opportunities supported by resources and funding can help support the career advancement of diverse employees. Changes in the workforce are also needed to increase the value of interpersonal skills, mentorship, and soft skills, and to ensure equity in funding opportunities.[172] These changes will better recognize the achievements of diverse members of the187rganizatinal community.[172]

A combination of solutions and modifications must be established to mitigate the barriers underrepresented racial and ethnic minorities in medicine, women, and LGBTQ+ clinicians face.

Caregiving Responsibilities

Diversity and equity initiatives must consider that the responsibilities of caregiving are not equitably distributed, and that circumstances, especially in regard to gender and cultural considerations may influence the extent of caregiving responsibilities for any particular healthcare professional. In the healthcare profession, when hours are often long and inflexible, the conflict between work and caregiving responsibilities can create tension, which affects burnout rates, retention of clinicians, and the overall effectiveness of the healthcare system.

Pregnancy and Family Planning

Medical education and training together involve years of intensive effort usually in a person's twenties and thirties, a period that coincides with prime reproductive years. Consequently, American female physicians report attempting to delay pregnancy, "timing" pregnancy to better fit demands of training, and even terminating pregnancies because of their careers, all at higher levels than seen in the workforce in general.[173] The biological realities of family planning and pregnancy are such that women who delay or attempt to "time" pregnancies optimally can experience increased struggles with fertility. Notably, pregnancy itself is a condition requiring frequent medical follow-up, and medical students and residents perceive low support for their pregnancies.[173]

Inequalities enter the field relatively early in the process, with women trainees feeling relatively more discouraged from pursuing specialties seen as unfriendly towards concerns around marriage or children.[174] Currently, medical schools lack a standardized approach to family leave policies, and those schools that do make policies regarding the issue are restricted by the relatively inflexible timelines of medical training, with historically strict deadlines for residency applications and testing.[175,176] As trainees enter residency, equally inflexible deadlines for fellowship applications affect their ability to take leave to care for their children or other family members, with research demonstrating that a 12-week leave during residency delays fellowship by a year in most specialties.[177] For many years, there existed no standard approach or policy to provide residents with family leave and because of this, guidelines within programs lacked clarity.[178] Female trainees have been affected disproportionately by this situation as the burdens of pregnancy and caregiving predominantly fall upon women.[177] Female attending physicians experience similar concerns, with many reporting conflict between domestic responsibilities and the workplace.[179] In the long term, this affects the likelihood that women will seek leadership roles, contributing to organizational climate and further perpetuating the problem.[180] Overall, conflict between workplace and caregiving responsibilities leads to depression and burnout, which results in an enormous cost to the clinician, to the organization, and to the field of medicine as a whole.[181]

Fortunately, deficiencies in resident family leave policies are increasingly being acknowledged by specialty organizations, and review and revision of policies to offer more support for resident and fellow trainees has begun. The American Board of Medical Specialties is working toward providing a minimum of six weeks of parental, caregiver, and medical leave without requiring an extension in training.[182]

Parental Leave and the Transition Back to Work

Given that the landscape of family leave policies is in the midst of revision, it is important to consider what components should be considered during a design and implementation process.[178] The WORLD Policy Analysis Center states that six months of paid leave is the ideal goal for parents of infants, with three months of paid leave as a minimum.[183] As even three

months of leave can have the effect of a substantial delay on training, the implementation of a six-month leave policy poses significant difficulties to trainees and institutions.[177] Part of the rationale for this length of leave is that it provides support for breastfeeding and for the provision of high-quality child care.[183] Workplace lactation interventions, such as lactation rooms and protected time, have the potential to ease the transition back to work without significantly compromising breastfeeding success, and laws governing their provision vary throughout the United States.[184] Other significant contributors to negative return-to-work experiences include difficulties obtaining childcare, stemming from inflexible schedules and differences in pay if part-time work or consistent hours are sought.[185] Implementation of on-site affordable childcare, schedule flexibility, and opt-out family leave policies have the potential to significantly improve the careers of clinician parents (CG) (CM). Complicating factors to the implementation of these programs include the effects on colleagues, including other trainees, which may lead to stigma.[178] Pregnant trainees witness and experience negative comments about pregnant trainees, and perceive stigma and pressure against their choices.[126] As pregnancy, breastfeeding, and responsibilities for the care of newborn and young children fall disproportionately to women, it is critical to address these factors to improve retention of women at all levels of training and leadership.[179] Additionally, LGBTQ+ parents can face discrimination if their employer's parental and family leave policy is not gender-neutral. In a 2018 survey of LGBTQ+ employees, only 45 percent indicated that their employers have LGBTQ+-inclusive leave policies.[186]

Elder Care

Caregiving responsibilities are not limited to minor children, but also include aging parents.[193] The elderly population is expanding as baby boomers age and adult mortality declines. By 2030, it is estimated that 1 in 5 persons in the United States will be over 65 and their number will exceed the number of children.[188] Dementia and chronic disease rates are expanding proportionally. Often, the option of "formal" or paid care is unaffordable and impractical. The tremendous burden of care for these parents and grandparents is taken on by the families of their adult children, and disproportionately by women in the family who may be, otherwise, fully employed. This creates an additional (unpaid) work shift, or even a third if they have children.[189] The economic value of this unpaid work was estimated at about 20 percent of total national health care expenditures in 1999 with this percentage likely to be higher now due to the increasing number of elderly in our population.[190,191] The term "sandwiched couples" is applied to families faced with both childcare and elder care responsibilities. These "sandwiched couples" experience increasing stressors and worsening wellbeing, with this effect being especially pronounced among women.[192] Differences between racial groups are also pronounced, with Asian and Hispanic caregivers spending more hours on caregiving than other groups.[193]

Patient Relationships

Relationships between patients and clinicians are the fundamental basis for the healthcare system. It is the consensual relationship between clinicians and patients that fosters mutual respect in autonomy, confidentiality, informed consent, and commitment of care. While these relationships can be a source of comfort and support for both patients and clinicians, failure to recognize challenges or maintain a positive dynamic by either party can have outsized consequences on clinician retention, patient care, and overall effectiveness of the healthcare system. These disruptions in patient-clinician relationships exist in multiple forms, both explicitly and implicitly. Discrimination, bias, and mistreatment all impact the foundation of quality care. Since bias and discrimination in a patient-clinician relationship often have bidirectional causation, both bias from and bias toward clinicians have been included, as well as patient-clinician mismatch, as well as systemic factors. While no discussion of these factors can be exhaustive, we address important examples of each in turn below.

Clinician Bias Toward Patients

Bias and discrimination by clinicians against their patients can exhibit some of the most corrosive effects on the patient-clinician relationship. A systematic review of 15 studies of implicit racial and ethnic bias found that most clinicians have both a positive implicit bias toward white patients and a negative bias toward people of color.[194] Further, these biases have significant effect on patient-clinician interactions, treatment decisions, treatment adherence, and patient health outcomes.[194] For example, one study has shown that racial bias and perceived discrimination impact adherence to treatment recommendations.[195] Another demonstrated that white medical students and residents who adhered to false beliefs about biological differences between white and Black patients were more likely to rate Black patients' pain as lower and to make less-accurate treatment recommendations.[18]

The 2015 National Healthcare Quality and Disparities Report documents how white patients receive better quality of care than Hispanic, Black, American Indian/Alaska Native, and Asian/Pacific Islander patients.[196] In another example, a study of women ages 18-55 found experiencing perceived discrimination was associated with lower preventative screenings such as Pap smears, mammography, and breast exams.[197] Similarly, multiple studies have shown implicit bias by clinicians against sexual and gender minorities sufficient to negatively affect patient outcomes through negative impact on patient-clinician interactions, clinical decisions, and patient perceptions of care.[198]

Despite these issues, physicians and Pas are often ill-trained to address issues of bias. With regard to race, as one review states, "The standard practice for teaching about race and health in medical and public health schools is one in which race is often discussed, but conversations about racism are sidelined."[199] At least two surveys surrounding training and attitudes around care for transgender and gender-nonconforming patients, one of emergency medical service clinicians and one of medical residents, show that many clinicians considered themselves and their peers as being insufficiently trained to support this population, despite their desire to provide quality care.[200,201] This failure can occur even at all levels of training—a survey of medical schools suggests that implicit bias is not routinely addressed in medical school curricula, and that training directed toward competency with vulnerable populations is infrequent.[202]

Indeed, one review suggests that the impact of clinician bias may *worsen* as professionals progress in their training, possibly as ingrained attitudes about particular populations based on

biased personal sampling of patient interactions.[194] Additionally, even when training does attempt to address issues of cultural understanding, many training programs can devolve into "exoticiz[ing] patients while obscuring social context, medical culture, and power structures."[203] By contrast, approaches based on structural competency, cultural humility, and cultural safety may provide a better way forward, encouraging commitment to "self-reflection and mutual exchange in engaging power imbalances along the lines of cultural differences."[199] Further work is needed to develop robust education that can better provide clinicians with the critical and communicative tools to connect with their patients and understand the systemic context around their patient encounters.[199,203,204]

Patient-Clinician Mismatch

In the US, it is very common for patients to have a clinician of a different race. Due to the racial and ethnic makeup of U,S. healthcare clinicians, non-Hispanic white clinicians more frequently provide care to racial minorities than do minority health professionals.[205] Racial or ethnic concordance may be preferred by many patients, especially when those patients have experienced communication problems in the past.[206] One study found an association between race and ethnicity concordance and likelihood of patient visits in Asian and Hispanic patients.[207] A large systematic review found that while Black patients experienced poorer communication quality, information-giving, patient participation, and participatory decision-making than white patients, racial concordance improved communication across many domains, including communication satisfaction, partnership-building, and length of visit/time and talk-time ratio.[208]

A 2017 survey showed that gender concordance between patients and physicians led to more preventive screenings in breast cancer, cervical cancer, and colorectal cancer. However, the study also showed that ethnic concordance of Hispanic patients and Hispanic clinicians led to less breast and colorectal cancer screening compared to Hispanic patients with non-Hispanic clinicians.[209] Another study in 2011 indicated that dual concordance in ethnicity and gender between clinicians and patients did not result in high ratings in clinician communication.[210] In addition, patients in gender-concordant relationships were more likely to report mammography adherence, and dual concordance was associated with higher second-year physical health status.[209,210]

Nonetheless, these two studies showed relatively small effect size and may be confounded by factors such as sampling limitation, perceived bias, effect of translators, insurance status, and clinician and patient attitudes, making the causal relationship difficult to delineate. Furthermore, mismatch report discrepancies could be due to the difficulty in translating subjective factors such as culture, language, and social characteristics into objective causalities. It is clear that more research needs to be performed on objective and subjective effects of patient-clinician mismatch.

Patient Bias Toward Clinician

The patient-clinician relationship may also be negatively affected by patient bias or behavior. Racism, sexism, and discrimination against gender and sexual minorities present a strong barrier for the development of positive patient-clinician relationships that can last long beyond a single discriminatory encounter. While discrimination against women clinicians has been studied for years, sexual harassment of women clinicians continues to be considered a routine "hazard of the job".[211,212]

Similarly, refusal of care based on clinician race is a known problem in many institutions, yet little guidance is provided for navigating the ethical responsibilities, both to the patient and to the

clinician, inherent in such situations.[213] Another study found that more than 30 percent of patients indicated that they would change clinicians if they discovered their doctor was gay.[214] Beyond the obvious immediate harm, clinician harassment may increase rates of clinician burnout. Two studies, one on vascular surgery residents and one on general surgery residents, found high rates of reported gender and race based discrimination and associations between discrimination and burnout, with patients and patients' families being the most common reported sources.[215,216] Another study, this time of pediatric trainees, reported a similar connection between patient and patient family discrimination and physician burnout.[217] While requests for accommodations based on race, gender, or sexuality may sometimes be appropriate and beneficial in terms of patient-clinician concordance, reasonable limits may be placed on patient conduct, and clinician comfort must be considered as well.[213] Working to address patient needs without compromising personal safety and principles takes practice.[218]

Institutions should support clinician efforts to create a safe work environment while still supporting good patient care. In order to do this, institutions need to develop explicit systematic approaches to management of patient bias. These approaches should include procedures that account for the clinical roles and services, establish trainee-specific procedures, make considerations for the role of bedside nurses, create a mechanism for reporting incidents of patient bias, designate a team to support staff and implement the policies and procedures that have been developed, ensure tracking and data collection, and ensure adequate training for addressing bias-based patient behavior.[213]

Systemic Factors

Patient-clinician relationships are deeply founded upon the interaction between two parties to ensure concerns and treatments are shared adequately with compassion and empathy.[219] One factor that negatively impacts the experience is restriction on the time a clinician can spend with a patient. A study asked the question "How many patients can one doctor manage?" and suggested that there are limits to the number of patients one clinician could effectively care for.[220]

It is imperative for clinicians to recognize the upward limit on the panel size, as too much workload would lead to a decrease in quality of care and increase in patient wait time. By defining the panel size, clinicians allow patients the flexibility to choose clinicians, allow clinicians to define workload and predict demands, and allow themselves to track performance and patient outcome. This exercise should further be emphasized if there are large differences in panel size or patient complexity/needs between clinicians.[220]

Additionally, at least one study has found a connection between panel size and clinician burnout, but concluded more evidence was needed to establish the association.[221] Further, as patients seek out clinician concordance, patient panels—and the attendant expectations that come with them—may disproportionately affect certain types of clinicians. For example, women physicians have been found to have higher percentages of women patients as well as psychosocially complex patients, and with these a pressure for longer visits that are often not supported institutionally.[222] This can lead to increased feelings of burnout.[222]

It is also worth noting that clinicians practicing in a rural setting may have different experiences than those who practice in non-rural settings. Rural populations have increasingly comprised elderly persons, as shown by an average age of over 65 in hospital admissions, while clinicians have to overcome barriers particular to rural medicine, including lack of coordination between healthcare systems, lower presence of specialty care and technology, lack of transportation, and

socioeconomic determinants of health.[223,224] While rural clinicians may feel deeply connected to their patients and communities and the patient-clinician relationship may remain a primary motivator for clinicians to practice in a rural setting, some clinicians report racial and ethnic, sexual, and gender biases and discrimination on an institutional level. When clinicians fail to find acceptance in the rural setting, this may worsen both the deeply valued patient-clinician relationship and, eventually, clinician retention rate.[147,225] Every institution and community plays various roles in impacting clinician and patient experiences; therefore, it is important for each workplace to proactively recognize areas of improvement and prevent over-generalization.

Pay

The Association of American Medical Colleges defines salary equity as “whether or not individuals have access to opportunities that allow them to earn and be paid similar compensation for comparable work, given shared qualifications, regardless of differences in individual characteristics such as gender, race, age, sexual orientation, religion, and disability.”[226]

Substantial differences in pay exist for women and ethnic and racial minoritized groups in the medical profession when compared with white and/or male counterparts. This is repeatedly demonstrated in studies and is persistent despite attention called to these differences. The lower pay when compared to physicians and Pas who are white and/or male is not accounted for by potential explanatory factors such as age, years of training, work hours, choice of specialty, clinical and academic productivity, rank, and leadership positions.

In studies that examine these differences, the pay gap is statistically significant, starts early in the career, does not get better over time, does not get better with career advancement, is not accounted for by clinician choices or preferences, and penalizes retirement security for those affected. Correcting pay inequity in the medical profession is fundamental to and tied to correcting inequity overall in the field. Equitable compensation is more likely to be achieved after also improving advancement strategies, inclusion, and culture. Shifts in culture coupled with transparency create the opportunity to challenge and push for change. These changes will come when a diverse workforce is embraced as an imperative.

The gender gap in pay can be found throughout the course of a career, and explanations remain elusive. One study, based in the state of New York from 1999-2008 examined the difference in pay for newly graduated physicians, demonstrated that the gender gap in pay at the start of career has increased from a $3,600 to a $16,819 difference during that timeframe. Adjustment for possible explanatory factors did not erase this difference.[227]

Furthermore, these researchers have demonstrated that the gender difference in pay for new graduates has not improved on its own, despite increased representation of women in the profession over time. Adjusted differences in mean starting salary, controlling for other factors, increased from $7,700 in 1999 to $20,200 in 2017.[228] In the academic environment, Jagsi et al. showed a substantial unexplained gender difference in salary within a cohort of early-career physician researchers as well (+$10,921, P<0.001). This was persistent even after adjusting for specialty, academic rank, work hours, research time, and other factors. Adjustment after consideration of spousal employment status (hypothesized to explain men needing a higher salary due to the notion of a “family wage”) left 10 percent of the salary disparity unexplained.[229]

This difference does not appear to improve over the course of an academic career. An earlier study by Jagsi et al. also demonstrated that among a homogeneous population of mid-career physician scientists, male gender was associated with higher salary (+$13,399; *P* = .001). Again, this difference was found even after adjustment for specialty, academic rank, leadership position, publications, and research time.[230] Furthermore, when examined, trends do not show resolution of these differences. A study examining data from the Current Population Survey compared median annual earnings over the interval from 1987-2010 and demonstrated that the difference between earnings of male and female physicians across occupations, adjusting for age, sex, race, hours worked, and state, continued to be 20 percent higher for male physicians

with no statistically significant improvement over time. Limits of this study included a lack of survey data on specialty, practice type, procedural volume, and insurance mix.[231]

These results and trends are reported repeatedly in surveys and studies seeking explanations for differences in pay based on gender.[232] Jena et al. looked at data on more than 10,000 academic physicians in 24 US public medical schools in 12 states using public information ranging from 2011-2013 and found that female academic physicians had annual salaries 8.0 percent ($19,879) lower than those of male physicians, representing 38.7 percent of the unadjusted difference in salary between men and women. In this study, adjustments were made accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue. Magnitude of sex differences in adjusted salary were noted to vary across specialties and institutions but were present at all faculty ranks.[233]

High representation of women in a specialty has not been shown to mitigate this effect. Pediatrics is the specialty with the highest percentage of women represented, as six out of ten practicing pediatricians, and seven out of ten graduating pediatric residents, are women. Female pediatricians report earning 76 percent of what men earn, or approximately $51,000 less annually. After adjustment for a comprehensive set of characteristics, women's reported earnings were around 94 percent of men's earnings, or about $8,000 less. In this study, it is suggested that earnings gaps may be related to mothers who might prioritize job flexibility and that periods of part-time work and not working are related to earnings.[234] When female physician prioritization of job flexibility over pay is examined carefully, however, studies provide mixed results. In a study looking at women hospitalists, women were found to earn $14,581 less than their male peers, despite adjusting for age, pediatric specialty, practice model, geography, type of clinical work, and productivity measures. Women hospitalists were noted to be generally younger than their male colleagues, less likely to be in leadership positions, worked fewer full-time equivalents, worked more nights, and reported fewer daily billable encounters. When considering job satisfaction, women ranked substantial pay fourth among their priorities, whereas male colleagues ranked pay second. In this study, women prioritizing pay below other priorities appeared to partly explain their lower earnings.[235] By contrast, another recent study using formal statistical decomposition techniques to assess impact of work-life preferences among other factors (including relationship status and family factors) found that salary differences were impacted only negligibly (<$1,000) by physician prioritization of work schedule control and flexibility. Additional analysis was restricted to primary care fields (internal medicine, family medicine, pediatrics) in which there is good representation in the data by both genders. The results were qualitatively similar and retained their significance.[228]

In another study examining physician compensation in internal medicine, the differential between men and women was higher among physicians who were practice owners than for employees ($72,500 vs. $43,000) and most pronounced between men and women in solo practices ($70,000).[232] More research is needed examining pay disparities outside academic practices, including in the independent practice arena, in which clinicians are often employees and to better understand gender differences for practice owners.

While less researched and less well-documented, salary inequities are also found for underrepresented minorities in medicine. A recent Medscape Physician Compensation survey in 2019, the most comprehensive and widely used physician salary survey in the United States, provides results from almost 20,000 physicians in more than 30 specialties. As in prior years, this survey demonstrates white physicians earn more than physicians of other races, with a range from $319,000 for white physicians, $303,000 for those of mixed or Latinx race, $300,000

for Asian, and $281,000 for Black physicians.[236] This supports persistence in the trends reported in multiple earlier studies looking at race and annual incomes based on specialty.

The additional intersectional impact of gender on race is noted to significantly compound or increase the difference in income for Black women physicians in pediatrics, internal medicine, obstetrics and gynecology, general surgery, and primary care in the 1990s.[237,238,239,240,241] Noting that the size and persistence of differences in annual income between Black and white US physicians from these prior studies relied on small samples of Black physicians and contained surveyed income data from nearly two decades before, Ly et al. reexamined the trends in data over 2000-2013 from the American Community Survey (ACS),a nationally representative, cross sectional survey of approximately three million households annually, administered by the US Census Bureau. Consistent with evidence in the overall economy that Black workers earn less, the ACS confirmed persistent adjusted differences in median income over this time especially between white and Black male physicians. Differences in median income by gender were also present and of larger magnitude than differences in race overall.[242] More research is needed to better understand any differences that may be present in compensation for UriM subgroups and the factors impacting these differences.

Observable trends in physician salaries are mirrored in the compensation disparities seen for physician assistants. In one study published in 2009 examining data from the American Academy of Physician Assistants (AAPA), new graduates demonstrated a significant gender gap in annual income.[243] This was confirmed in a later study looking at multiple specialties including orthopedic surgery, emergency medicine, and family practice. Male physician assistants reported a higher total income, base pay, overtime pay, administrative pay, on-call pay, and incentive pay, independent of clinical experience or workload.[244] Female PA educators also earn less than male counterparts, and this difference was not explained by education level, rank or position.[245] These differences in compensation are also present in repeated studies, even when controlled for experience, hours worked, specialty, postgraduate training, region, and call.[246]

Studies on racial and ethnic differences in physician assistant salaries are less definitive due to the very low percentage of minorities found in the field. In one study, racial and ethnic differences in salaries for physician assistants were examined using AAPA data from 2009 examining white, Black, Hispanic, Asian, and other groups. Results were controlled for many variables including education, specialty, hours worked per week, years in specialty, and size of city. No differences were found by race and ethnicity when the other variables were included in the analysis, but there were very low percentages of minorities found in the field.[247] In another study, minority Pas had a trend to make slightly higher income than white counterparts, but this result was not statistically significant.[48] A bias in the AAPA data is suggested due to lack of minority representation. A follow-up study looking at results from the American Community Surveys data shows that the salaries of Black and Hispanic physician assistants lag significantly behind the salaries of their white counterparts and that the salaries of female Pas are substantially below those of their male counterparts.[248] More studies are needed, as well as a better understanding for the low representation of UriM in the PA community.

Existing literature related to the US medical system has not examined the effect of sexual orientation and gender identity on compensation for physicians and physician assistants. However, literature looking at discrimination targeting LGBTQ+ members of the general workforce demonstrates significant pay differences, though data are limited; this is likely a consequence of the United States' history of legalized discrimination policies in employment and

other facets of daily life. Until a June 2020 US Supreme Court decision,[249] it was still legal to discriminate in employment on the basis of sexual orientation in over half of US states. Previous federal administrations have issued executive orders that provide piecemeal protections that have been subsequently revoked by later administrations.

Although data on economic disparities affecting the LGBTQ+ community are sparse and superficially conflicting, a high quality meta-analysis of published literature has shown that gay men earn on average 11 percent less than heterosexual men.[250] The evidence is even stronger that partnered gay men suffer an earnings penalty, though some data from more recent studies show a smaller difference than studies from longer ago. Partnered lesbian women enjoy a 9 percent earnings premium compared to their heterosexual counterparts. Some studies find these disparities fade when non-coupled individual sexual minorities are included. However, this has been shown to be likely due to unmarried gay men being able to disguise or mask their sexual orientation. Bisexual men also earn significantly less than otherwise similar heterosexual men. And finally, lesbian women consistently earn less than men, demonstrating that gender discrimination has an even greater impact on wages than sexual orientation discrimination.[251,252,253,254]

Several studies have objectively demonstrated discrimination in hiring practices of LGBTQ+ workers.[254,255,256] In self-report surveys, 15-43 percent of LGB respondents reported discrimination in the workplace. A similar number of transgender workers also report employment discrimination.[257]

A large US-based national longitudinal study had several notable findings. Compared to heterosexual cohorts, sexual minority women and men were both less likely to be homeowners. Many inputs likely contribute to this, including earnings, non-equitable access to health insurance, only recent nationwide access to the benefits of marriage, strained parental relationships resulting in limited familial assistance, and intergenerational transfers. And though SM men were more likely to have completed higher levels of education than their heterosexual counterparts, they were more likely to earn under $10,000 annually and be unemployed. Adjusting for education magnified the inequities, suggesting likely significant discrimination.[258]

Sexual orientation-based and gender identity discrimination has been demonstrated to be a common occurrence in many workplaces across the country, and such discrimination often translates into lower pay.[257,259] While no known data exist regarding the effects of LGBTQ+ status in the healthcare workforce, it is likely that the medical profession is not exempt from this problem. More research is needed to confirm that disparities in pay and advancement found for other minoritized groups in medicine also apply to the LGBTQ+ members of the medical community.

Opportunities and Challenges for Correcting Pay Inequities in the Medical Profession

As we aim to create a more diverse medical workforce to serve an increasingly diverse population, attention must be given to equitable pay practices. Research outside the medical profession has demonstrated that employees who believe they are paid fairly are more engaged, less likely to quit, experience less stress at work, feel healthier physically and emotionally, and are more satisfied in their personal lives. In addition, gender discrimination lawsuits are costly, result in lost productivity, and destroy morale while damaging the business' reputation.[260] These findings also apply to the medical profession, as inequitable pay practices in the medical profession have a significant impact on retention and job satisfaction for underrepresented minorities; racial and ethnic minority faculty are significantly less satisfied with

their careers and are more likely to leave academic medicine within 5 years.[261] Women and minority faculty cite multiple reasons for leaving medical school positions, including issues with career advancement, low salary, and chairman/department leadership issues.[262]

Advancement and Promotions

Advancement and the factors affecting advancement in the profession have an impact on annual compensation. Many reported barriers impeding the entry and advancement of women, UriM, and LGBTQ+ physicians and Pas exist in the medical profession, and these need to be addressed. These include: biases in hiring and decisions about advancement (in this case including impact on starting salary and pay raises); linguistic biases demonstrated in letters of recommendation and evaluations that can affect these decisions; biased decisions regarding funding for research and publication of research; biases in decision-making for medical society leadership and awards; selection biases in opportunities for networking and prestigious speaking engagements; and limited opportunities to join networks of influence within medical groups and organizations.

All these factors influence compensation decisions in subtle or overt ways and must be corrected to improve pay discrepancies. Additional differences faced disproportionately by women in the workplace include decisions related to fertility and family constraints on the job hunt, which can limit the breadth of opportunities sought and found. Family care responsibilities, both for children and for elders or those with healthcare needs, fall disproportionately on women resulting in reductions in FTE with pay decreases, use of PTO for family care responsibilities, and even use of FMLA leave (which is without pay). These all can impact pay, advancement, and leadership opportunities inside academia and outside.

Payment Systems

The payment system under which a medical professional provides care can pose difficulties unique to that practice environment. Compensation in medicine in this country has traditionally been based on a productivity model, fee-for-service, with services assigned a certain value and insurance or payors covering that cost. Alternative models have been developed—including episode-based payment and population-based payment—which differ in how well they constrain spending, promote quality, and support clinicians. Each payment system comes with advantages and disadvantages and attention must be placed on the care delivery being incentivized.[263]

In a healthcare system that now consumes about 18 percent of gross domestic product, control of rising costs is a primary focus and forces scrutiny of any adjustments in the system. Therefore, if one person or group is provided with richer compensation, another will be provided with poorer, and adjustments are expected to affect other members of the department or team. This creates tension in how best to adjust the standard payment models for those factors that disproportionately affect women, underrepresented minorities in medicine, and LGBTQ+ clinicians. A decision to make such changes will reflect commitment to justice and willingness to challenge older standards.

Starting Salary

Achieving equity in the starting compensation for newly graduated trainees will require some standardization. Relying on human factors such as negotiation and decisions made by hiring teams automatically places some applicants at a disadvantage. Women have been shown to negotiate job offers less frequently than men and to suffer a “social cost” from negotiating when they do. Women do tend to be more successful negotiating higher salaries when their role is to

advocate for others as opposed to negotiating for more for themselves.[163] Literature has shown similar negative impacts for negotiation by Black prospective employees.[264] Once basic equity is achieved in the starting compensation, there are many factors at play that can affect pay or workload as a clinician advances in their practice.

Fee-for-Service

For those practicing in a fee-for-service (FFS) environment, insurance mix and referral base can impact compensation. Number of clinical encounters affects pay, and factors that slow encounters can have an impact on compensation, as well. Some examples of such factors include language barriers requiring use of interpreter services (also at cost to the medical practice) and socioeconomic barriers to the plan of care, which can prompt extended visits while negotiating the realities of a patient's resources. Distribution of patients in a clinical practice is usually not random, as patients with certain characteristics often self-select for one clinician over another (i.e. female patients selecting female clinicians, Asian patients selecting an Asian clinician, etc.). This has impacts on the practice that are not usually accounted for in the FFS environment. Female patients tend to generate more visits than male patients with rates of preventive care visits 69 percent higher.[265] In one study, 64 percent of all visits were by female patients, and these patients reported poorer health and higher rates of anxiety and depression, had more medications prescribed, and raised more emotional issues than men.[266] These differences represent increased complexity in the visit, which tends to impact time spent in care and workload. The differences affect female clinicians disproportionately compared with male clinicians, given female patient self-selection for female clinician practices. The time and effort needed to deliver care is not adequately captured by current payment models and disadvantages female and UriM clinicians. Bonuses based on RVU productivity will amplify these inequities and benefit those whose practices have high-volume, lower-complexity visits.

Capitation System

In a capitated system or population-based payment model, determining how the workload is defined becomes even more important. For those providing longitudinal care, differences in patient panel composition (gender, race, age, socioeconomic status, health literacy, primary language, etc.) can be drivers of visit frequency, complexity of issues addressed in the office, frequency of ED visits and hospitalizations, need for specialty consultation, and need for complex care coordination. Such drivers of care complexity are time-intensive, reduce the number of encounters/appointments one can have in a day, and overwhelm the resources of an individual clinician. This may result in decisions to reduce clinical hours and accept a reduction in pay while working beyond acknowledged or scheduled hours to meet the needs of the assigned patients.[221,267] Distribution of patients between clinicians is often influenced by factors such as the clinician's race or gender, and (again) can result in clustering of demographics in a medical practice. Additionally, clinicians may prefer a certain focus for their practice resulting in a patient population heavily weighted toward added complexity. Panel adjustment for patient mix and patient complexity is an imperfect but necessary solution for a large group practicing under this payment model.[268]

Patient Satisfaction, Quality Scores, P4P

Patient satisfaction scores and quality scores as measures used in determining compensation can also be problematic. Physician race and gender have been shown to influence Press Ganey survey ratings, which are widely used to evaluate physician and institution quality and performance.[269,270,271] Patient race and cultural factors influence Press Ganey survey ratings as well, but these effects are not currently accounted for in most health systems.[270,272] Use of pay-for-performance to improve the quality of care of a group of patients seeks to incentivize

improving outcomes. However, baseline reimbursements need to reflect a population's risk levels, and while P4P is a potential tool to monitor and improve health disparities, often performance measures do not address risk factors such as population disease burdens, access disparities, geographic and socioeconomic disparities, and race and ethnicity as independent health risk variables. Access to population management tools are needed to achieve successes in care of populations with significant healthcare inequities.[273] UriM and women in medicine are at risk of increased negative impact from use of patient satisfaction and quality scores.

Systems of Care

Academic Practice

The academic practice and added complexity of demands from teaching, research, and other roles within an academic institution adds to the challenges of correcting compensation inequities. Discretionary funds and resources may not be distributed in transparent ways. These resources can include seed funds, administrative support, professional allowances, and publication fees, and can all affect clinical productivity, quality of work, time spent at work, service, and scholarly output. Academic bonuses may be based on subjective valuation of contributions. Gendered and racial differences in research packages,[274] startup resources, and expectations about clinical workload impact downstream scholarly productivity and advancement. Endowed professorships, chairships, and appointed leadership positions add significantly to compensation packages but have not been similarly offered to women and underrepresented members of the profession. Finally, the impact of part-time status on tenure track, advancement pathways, and promotion criteria have not been clear historically and expectations may be measured against the benchmark of full-time colleagues. The full-time standard can impede the progress up the academic ladder, which is ultimately reflected in pay disparity. This may have a disproportionate impact on those whose career trajectories and other responsibilities do not mirror those of more traditional white male academic clinicians. Forcing faculty to choose between career and family hurts the profession's ability to recruit and retain the best and brightest candidates. Some would suggest that the culture of academic medicine must change to one in which flexibility and work-life integration are core parts of the definition of success.[275] Certainly, difficulty in retaining and advancing diverse members of the medical profession contributes to compensation disparities.

Hospital-based and Procedural Practices

For those whose practices are primarily based in the hospital (e.g. hospitalists, intensivists) and procedural arena (e.g. surgeons, interventional radiologists), there are additional challenges. Reimbursement can have a complicated relationship to referral patterns, and biases can be introduced that can have an impact on ultimate reimbursement. Relationships to payers for such practice types can be fee-for-service, individual contract-to-hospital, or group contract-to-hospital. For FFS, work is reimbursed by RVUs. Although some RVU assignments may be questionable, there are no clearly defined differences that can be related to gender, sexual orientation, or race/ethnicity. Individual contracts to hospitals are not protected from biases because the process is frequently opaque. How group contracts are handled with groups can vary considerably depending on group size, multispecialty vs. single specialty, and other characteristics. Transparency can be complicated in smaller groups as individuals can consider income confidential information. This, again, leaves room for bias to intervene, in addition to potentially causing friction on other levels. Transparency of how the contract payments are disbursed would appear to be the best defense against bias in contractual relationships. Differences in types of shifts and allocation of shifts can result in undesired differences in income. Department bias in distribution of highly sought-after shifts may have an unmeasured impact on compensation for individuals within a group. Distribution and reimbursement of cases

and procedures may also demonstrate bias. For example, gender specific-matched Current Procedural Terminology (CPT) codes have revealed reimbursement bias favoring male urologic procedures compared with similar female gynecologic procedures.[276] CPT codes also do not pay equally for procedures depending on the surgeon performing the procedure. Different specialties receive different pay rates for similar procedures. One example includes normal spontaneous vaginal deliveries which are paid differently if a Family Medicine, OB-GYN, or midwife is the clinician for this particular procedure.

The community in which the hospital or practice is located directly affects insurance mix or rates of uninsured and underinsured in the patient population. Bias in referrals and department processes for distributing cases may also have an unmeasured impact on compensation differences for targeted groups in medicine.

Employment in Large Health Systems and Government Practice

As the numbers of physicians and Pas working in employed positions in large health systems increases, there is loss of autonomy to manage practices and workload. This loss of autonomy impacts the ability to choose practice characteristics that may impact quality of care provided, workload, and compensation. Even physicians in government settings experience gender gaps in compensation, although in at least one study, significantly less than physicians in other systems, likely for similar reasons.[232] Systems for accounting for differences in medical practices need to be developed to reduce inequities in pay as well as multiple other downstream effects of inequities in workload and pay, such as reduction in work hours, burnout, worsened quality of care or outcomes, and attrition from the profession. Especially in large health systems, robust data, and transparency about the conflicting issues at play will be needed to inform change.

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APPENDIX N

APPENDIX N: SYSTEMIC RACISM

Equity Task Force
Systemic Racism Workgroup

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Recommendations

The Equity Task Force recommends:

1. **That the OMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and as a barrier to appropriate medical care.** Racism is part of American society and therefore part of American health care. Health care professionals have the ability and obligation to recognize and untangle the influence of racism and discrimination in medicine.
2. That the OMA **transform the Equity Task Force into a standing Justice, Equity, Diversity, and Inclusion (JEDI) Committee** to address justice, equity, diversity, and inclusion in our practice, institutions, and industry. OMA will ensure that the committee has a diverse membership and is of sufficient size to perform the anticipated functions. The committee will immediately develop a charter covering membership, function, and scope (which is to extend beyond issues of race, to include, but not limited to, those involving gender, sexual identity, ethnicity, religion, immigrant status and experience, language, disability, old age, poverty, and rural location). The committee will address tasks in these areas which they deem appropriate, but including:
    a. Educating OMA members on the **influence of institutional and individual racism** and other inequities on the practice of medicine.
    b. Advocating for policy changes that **improve equity in the health care professions and practice of medicine** in Oregon. This includes recruitment and retention of future physicians, physician assistants (PAs), and other healthcare workers from racially diverse communities and other underrepresented identities.
    c. Recommending methods to reduce the **impact of racism on public health** and health outcomes. This includes recognizing, addressing, and reversing racially differentiated **health outcomes** for our patients.
    d. Recognizing and addressing the major public health issue of violence against individuals because of personal characteristics. This includes identifying and supporting policies that **reduce violent injuries and death** among Black Americans and other people of color. In addition, especially during mental health crises, OMA will identify and support policies that **improve police interactions** with the community.
    e. Promoting recognition of the inequalities in upstream **social determinants** (e.g., family wealth, housing stability, food security, employment, education) and their influence on the health and outcomes of our patients, in order to begin addressing these as public health issues.
    f. **Expanding advocacy** to support policies that address these upstream social determinants.
3. That the OMA **collaborate with other organizations** to promote health equity, inclusion, and diversity. Examples of possible collaborations could include supporting the formation of an Oregon chapter of the **National Medical Association (NMA)**, work on equity policies and solutions with other **physician and PA organizations**, and continuation of OMA engagement with the **Oregon Health Authority, Oregon Health Leadership Council, and other organizations** in efforts to promote medical outcomes and improve social determinants of health.

Systemic Racism Workgroup Background

In 2020, police (and members of the public claiming to act in a manner of authority) killed a number of unarmed Black people. The news of these events spread instantly and widely through news outlets and social media platforms due in large part to video recording capabilities of modern cell phones. The police killing of George Floyd on May 25, 2020—though not materially different from the others—spread widely and in full undeniable detail because it was daylight, in public, and clearly recorded from beginning to end. This led to ongoing and intense public outcry across the nation and worldwide.

OMA responds:

In June of 2020, the Oregon Medical Association President and the Chair of the Policy Committee asked the OMA Equity Task Force to expand its scope of work and address systemic racism as a public health issue. The Equity Task Force called together a diverse group of volunteers from around the state who gathered to develop a report and recommendations.

In the previous year, the OMA's Executive Committee, at its retreat, drafted a new strategic plan for 2020 that included an update to the organization's Vision, Mission and Values. The revised mission calls for OMA to speak as the unified voice of medicine in Oregon; advocate for a sustainable, equitable and accessible health care environment; and energize physicians and physician assistants by building and supporting their community. Among the core values were solutions-driven leadership with attention to systematic problem-solving to support and empower OMA members to build a healthier Oregon and inclusivity pursuing goals with a focus on equity diversity and inclusion.

Taking this into consideration and because racism is a complex problem with centuries of history and intergenerational fallout leading to ongoing disparities impacting the health of the community, the workgroup sought to answer a number of questions with its report:

- What is racism?
- How does it impact people and communities?
- How does this relate to the health of our patients and communities?
- What role have physicians and the medical community played in perpetuating this problem?
- How is this a public health problem?
- What responsibility do we have to engage in solutions and how can OMA contribute?

Discrimination grows from the unjustified prejudices one group of people has against another group of people based on certain characteristics such as race, sex, religion, disability, and more. Often times, such discrimination leads to purposeful divisions within society constructed by those with power. These lines of division can manifest in different ways, but all offer advantages to those who have power. Lines of division are maintained by an imbalance in social control and physical authority and are embedded into the fabric of society. Such lines eventually become normalized for the advantaged side, while those targeted for exclusion suffer the consequences of their dispossession. The experience of each disadvantaged group has its own history and unique features but there is significant overlap. The problems created are not self-correcting.

The size and complexity of the entire problem is daunting and the creation of an inclusive treatise for all disadvantaged groups would require an exponential expansion of the task force. An attempt at a single comprehensive treatise for all minoritized groups could also distract from the goals of demonstrating how discrimination leads to systemic injustices and ongoing disparities, and how the permanent nature of these makes it impossible to render change without effort. This report focuses on the Black experience as an example of how structural

racism within national and state systems and institutions, including health care, impacts targeted people, with a close look at demonstrated impacts on the well-being and health of Black people and their communities. Events surrounding the Black community inspired the request for expanding the scope of OMA's Equity Task Force.

Although the Black experience in this country provides a powerful example of how systems of racism work, we acknowledge that systemic racism has significantly affected other racial and ethnic groups, and that discrimination also exists related to sexual and gender identity, religion, language, country of origin, and disability. While we will not thoroughly explore the experiences of other minoritized groups here, their experience, like that of the Black community, needs to be examined closely and addressed in the future.

In addition, we recognize that evidence, statistics, and scholarly work inform this report, however, we would be remiss not to also tell some of the individual stories of the impact and damage of racism which our members and others have experienced. This combination of data and medical humanities storytelling give a better and more holistic picture of this very complex issue and its impact on the healthcare professions and the communities we serve. Systemic racism is understood through sundry events knitted together, all of which are unique experiences. Medicine has traditionally made use of case presentation to expand on the human dimension of experience, though it is not common in OMA reports. Individually, these events can be interpreted as mere anecdotes or exceptions, and with this they become invisible. We bring them to light and integrate them into the story of racism told here.

Systemic racism is a problem in the United States and has been since before the beginnings of slavery when race as a social construct was intentionally developed to justify abuse and maintain power. This report briefly details the history of anti-Black systemic racism in the United States with its impact on housing, employment, political power, financial independence, policing, and health care. Oregon's systems and institutions are no exception.

The recent killings of Black people by police have thrust the issue of racism into national and international prominence. Attention has been focused on the public health impact of violent injuries and death at the hands of law enforcement and also on our model of community policing in general. Violence is a significant contributor to mortality rates for Black people and should be added to the list of major health problems. We discuss the complex contributors, rooted in racism, which set up the milieu for such violence.

We describe the impact of the War on Drugs in the Black community, including policies resulting in confrontational policing tactics and the rapid expansion of incarceration of Americans. These policies have disproportionately affected people of color, impacting individuals, families, and communities, and their health and wellness, as well as access to appropriate health care.

Black people experience bias in many aspects of life. Navigating the impacts of bias creates challenges in health care as well. There is a long history of inequitable access to health care and medical treatment. The racial disparities in health outcomes are rooted in all the impacts of cultural and systemic racism as well as racism embedded in care delivery systems.

Although the discrimination against any one particular group has its own unique history and complexities, social and public policy interventions addressing racism can be expected to be a rising tide that helps all disparaged groups. We build a case for the relevance of racism to the medical profession given downstream effects on health outcomes and resultant public health.

We call on the Oregon Medical Association to actively address issues related to race and offer the recommendations listed above for influencing policy, with a goal of improving health outcomes in all communities targeted by systemic racism and other related forms of discrimination, and for continuing to improve the environment in which we practice for all members of the health care community regardless of personal characteristics. Making our recommendations part of OMA policy will help us support and become leaders in the transformation of health care to an anti-racist industry.

A Chronology of Racism: The Black Experience

History, as nearly no one seems to know, is not merely something to be read. And it does not refer merely, or even principally, to the past. On the contrary, the great force of history comes from the fact that we carry it within us, are unconsciously controlled by it in many ways, and history is literally present in all that we do. It could scarcely be otherwise, since it is to history that we owe our frames of reference, our identities, and our aspirations.

James Baldwin, Ebony, August 1965[1]

Racism can be considered to have three inseparable aspects. There is a longitudinal experience which stretches over generations. There is bias (aka. bigotry) which has perpetuated and maintained this experience. There is also contemporary life which has been infiltrated by this experience in manifold ways. In order to address the negative impact of systemic racism on health in the present, we must first describe how we got here. We begin with a historical summary of the American Black experience. Before the Civil War, systemic racism in the form of sanctioned slavery was woven into the fabric of the United States. We focus most of our discussion on the time following the Civil War, where more detail is provided.

Historical Summary of the Black Experience in America

The “American Dream” of “Life, Liberty, and the pursuit of Happiness” in its original conception was reserved for white men with property. Expressly stating the intention of excluding people of color and all females was unnecessary as this was widely understood by those in positions of power and authority at the time this phrase was penned.

The systems that provided preferential treatment to those in power remained in place for centuries and remain embedded where they have not been actively reversed. Therefore, systemic racism in its various forms has had a longitudinal, intergenerational impact for Black Americans, extending from 1619, when enslaved Africans were first brought to North America, through to the present day.[2]

Before the Civil War, the vast majority of Black Americans in the United States were enslaved.[3] In 1860, there were about 400,000 free Black Americans, compared to four million enslaved Black Americans.[3] The 13th amendment became law in 1865, abolishing slavery and abruptly resulting in millions of freed slaves entering the depressed postwar economy of the war-torn south without adequate resources for self-sufficiency.[4] The Freedmen’s Bureau was a government agency established in 1865 to provide aid to former slaves but could not meet the demand.[5,6] While some slave owners were compensated for loss of slaves due to the emancipation proclamation, no former slaves were reimbursed for their many years of enforced uncompensated labor which predated emancipation.[7]

Post Emancipation period with Post-Civil War and Presidential Reconstruction: 1862-1867

The period immediately following emancipation was a predictably precarious time for recently freed men and women. It is estimated by Connecticut College historian Jim Downs, in his book "Sick from Freedom," that approximately 25 percent of the four million freed slaves died or suffered significant illness between 1862 and 1870.[4] Some received medical aid by a short-staffed Freedmen's Bureau. They suffered from illnesses such as smallpox, cholera, and dysentery, in addition to malnutrition and exposure.[4] Dependable statistical records regarding disease and mortality in ex-slaves during this time are not available. However, given the mortality rates of these illnesses (even with "medical treatment") and the fact that many who had these illnesses were not treated, it can be concluded that the mortality rate was significant. Freed slaves were frequently attacked by bands of confederate guerillas, were spurned by many southern whites (who did not consider them to be citizens, or even fully human in some cases), and were without adequate support for basic needs such as food, clean water, and shelter.[8] During this time, the South had no effective government. The south was policed by federal soldiers who were essentially an occupying army. Their focus was keeping the peace and dealing with confederate guerilla bands, not with attending to the needs of ex-slaves. Coming out of slavery, freedmen were mostly illiterate (teaching slaves to read and write was illegal due to Slave codes) and most had little understanding of the monetary value of their labor or how the economy worked. Employment opportunities were available, but employers had no obligation to reimburse those employed (14th amendment, affording citizenship and equal protection under the law, was not ratified until 1868). It is likely that there was a tendency on the part of ex-slaves to avoid long term employment, which was interpreted as laziness by southern whites.[4,9,10]
When President Abraham Lincoln was assassinated at the end of the Civil War, Andrew Johnson, a former slave owner from Tennessee, became President. President Johnson had a lenient policy toward the ex-Confederate states, deferring to the state governments to determine the rights of freed slaves.[11] As a consequence, Black Codes, laws that circumscribed the rights of Black Americans, were enacted in the states that had been part of the Confederacy, severely restricting the rights of the newly freed slaves, adding to their struggles.[12,13] Black Codes in some southern states had the effect of providing inexpensive labor for white employers. Under Black Codes, many states required Black people to sign yearly labor contracts; if they refused, they risked being arrested, fined, and forced into unpaid labor. Black Codes limited what jobs Black people could hold, as well as dictating if or when they could leave their employment.[10,14,15]

Congressional Reconstruction: 1867-1877

The Reconstruction Act of 1867 weakened the effect of the Black Codes by requiring all states to uphold equal protection under the 14th Amendment, particularly by enabling Black men to vote as citizens. Voting was further protected by the 15th amendment which more directly enfranchised all citizens of the United States.[16] For a brief period following the elimination of the Black Codes and ratification of the amendments, Black people achieved considerable economic and political success. During Reconstruction, many Black men participated in politics by voting and by holding office. For example, there were as many as 16 Black congressmen elected from 7 different southern states.[17] Many more Black Americans were elected to local public offices. Hiram Revels and Blanche Bruce, both Black men, even served in the U.S. senate.[18,19] Because there were skilled laborers among the ex-slaves, a number of "freedmen's towns," were constructed in an attempt to create an independent existence without dependence on white people or the government.[20]
The removal of Black Codes and passage of the 13th and 14th amendments caused a white backlash and motivated the Ku Klux Klan.[21,22,23] A number of violent and deadly attacks on freed Black people occurred, as evidenced by the Colfax, Louisiana Massacre in 1873.[24] Congress passed the Enforcement Acts, also known as the Ku Klux Klan Acts (May 1870, Feb and April 1871), empowering the President to use military force to protect Black people. The Enforcement

Acts were used by President Ulysses S. Grant to counter the violence and intimidation toward Black people.[25]

The End of Reconstruction and the Preservation of White Supremacy in the Face of Constitutional Headwinds: 1877-1923

At the end of formal Reconstruction in 1877, an even more intensely violent anti-Black backlash occurred.[26] There was a return of large-scale disenfranchisement of Black people and segregation was mandated when southern states, counties, and cities enacted Jim Crow laws. Jim Crow laws were state and local statutes that legislated racial segregation. “Pig Laws”, similar to Black Codes and Jim Crow laws, resulted in harsh penalties for Black people. If a Black man did not have a job satisfactory to white law enforcers, he was incarcerated, and incorporated into a free Black labor force for white businesses. Additionally, “Pig Laws" unfairly penalized poor Black people for crimes such as stealing livestock. Many trivial offenses and misdemeanors were treated as felonies with harsh sentences.[27,28,29,30] Black people had limited opportunities and lacked resources to assert their rights through legal challenges, but when they did, these efforts were unsuccessful.[31]

In 1896, the Supreme Court delivered the “separate but equal” ruling in Plessy v. Ferguson. This decision was applied to a man who by appearance was White, but who had a modicum of Black ancestry. He protested being forced to sit in the Black section of a train. He took his case to court, and it was eventually heard in the Supreme Court. The decision was a 7 to 1 ruling in favor of separation of the races on trains. Although this was thought to be a trivial ruling at the time, its impact was ultimately pivotal in that it provided a precedent for segregation and Jim Crow. This supported continuing segregation in the south, but also encouraged it in the north. Segregation of housing, schools, swimming pools, beaches, hospitals, government, bathrooms, water fountains, theatres, stadiums, public transportation, and other entities was now constitutional through this editorializing verdict of the Supreme Court. Segregation, which should have been unconstitutional according to the 14th Amendment, was now a sanctioned practice.[30,32] From that time until the Civil Rights Act of 1964, this form of dehumanizing discrimination was legal and enforceable.[33]

Without the benefit of federal protection, many towns founded by Black people were ultimately destroyed by white people with the inhabitants brutally murdered. Prominent examples include the Wilmington Massacre in North Carolina in 1898[34] and the Atlanta Massacre in 1906.[35] Without the ability to own land, life for many Black people in the south was reduced to sharecropping and other dependent, subordinate means of existence.[36] This was the beginning of Black incarceration contributing to a statutory racial caste system, which resulted in additional loss of protected rights and access to the privileges of citizenship for many in the Black community.[27]

Overt forms of systemic racism, such as Black Codes and Jim Crow laws, later gave rise to less overt and more insidious policies. One example of such policies was the grandfather clause, which stated that a man could only vote if his ancestor had been a voter before 1867.[37] Because the 14th Amendment was ratified in 1868, this essentially prevented any Black man from voting. Additional discriminatory tactics included the literacy test and poll taxes. The literacy test was applied by the county clerk, who was white and would intentionally give Black voters extremely difficult legal documents to read as a test, while white men received easier texts. Poll taxes effectively excluded many Black and poor people from being able to vote. Finally, in many places, white local government officials physically prevented potential voters from registering.

These policies ensured that Black people were not proportionally represented in government and prevented them from having any political power to impart change.[38]

These policies were extremely effective in achieving their goals. During Reconstruction, Black people were a majority of the registered voters in Mississippi, Alabama, Florida, Louisiana, and Georgia.[39] At that time, the percentage of Black voting-age men registered to vote was greater than 90 percent. By 1940, the percentage of eligible Black voters registered in the South was only three percent.[39] Examples of voter suppression still exist today.[40,41,42,43]

Northward migration of Black people was welcomed during World War I (WWI), as an expanded workforce was necessary to provide the needed equipment and weapons for fighting the war.[44] However, the approximately 40,000 brave Black men who fought in combat overseas for the United States during WWI were met with racism and discrimination both in the military and upon returning to civilian life.[45] Although the volunteer "'colored regiments" were disbanded after the Civil War, segregation remained in official military units.[46] During WWI, there were four all-Black regiments led by white officers. There were more Black volunteers during WWI to fill the numbers needed for these units, and so additional units were made with Black officers. However, there were still efforts to bar Black individuals from serving in the Marines and efforts to prevent Black service on top of segregation.[46] Black men were instructed to mark their registration cards in order to be drafted separately from white men.[46] In addition, many individuals were falsely accused of dodging the draft and arrested when postal workers conspired to withhold their registration cards. Many Black WWI heroes never received the Medal of Honor for their recognized acts of valor as a result of racism.[45] Black soldiers faced countless acts of disrespect, discrimination, and received subpar equipment and accommodations.

The United States military was not ordered to desegregate until 1948.[45] A lack of diversity in top military positions and reports of continued racism in the military are still seen in recent years.[47] The U.S. House Armed Services Committee held a hearing on the "Alarming incidents of white supremacy in the military—how to stop it?" in 2020, further demonstrating the continued presence of racism within our nation’s military.[48]

As white and Black soldiers returned to the United States, Black employment was met with resistance. Black workers were seen as competing with whites for jobs.[49,50] Returning Black soldiers were met with increased violence from white civilians with documented increases in race riots and lynchings.[46] Tensions over civil rights and social and political rights of Black people led to the East St. Louis and Newark massacres in 1917, and race riots across the country, most notably in Washington, D.C. and Chicago in 1919.[51]

In Chicago in 1919, a young Black man, Eugene Williams, was swimming in Lake Michigan and drifted into an area tacitly reserved for white swimmers. He was pelted with stones and drowned. A disturbance ensued and ultimately, a riot and destruction of property; 38 died (23 Black citizens, 15 white), 537 were injured, and 1,000 were made homeless.[52] Ironically, these events occurred in a town founded by a free Black immigrant from Haiti, Jean Baptiste Pointe DuSable.[53]

In 1919 alone, there were 25 riots and 97 lynchings of Black people including the killing of up to 100 African Americans by white law enforcement officials and vigilantes in Elaine, Arkansas after Black sharecroppers tried to organize a union asking for better working conditions.[54,55] The summer of 1919 has been called the “Red Summer,” a term coined by James Weldon Johnson

in an article written for the National Association for the Advancement of Colored People (NAACP).[55]

The period from 1917 to 1923 saw some of the worst racial terrorism with numerous incidents of white mobs attacking Black people and their communities.[55,56] Black soldiers returning from fighting for the United States in WWI had proudly risked their lives and shed blood for democracy, to fight for the side of life, liberty, and the pursuit of happiness.[51] They felt they deserved to participate in the American Dream at home. This was met with lynchings and a resurgence of the Ku Klux Klan.[50] In the early 1900s, Greenwood, Oklahoma, a mostly Black section of Tulsa, Oklahoma, became the home for a thriving community known as “Black Wall Street“. During the post-war period of white racial unrest, this prosperity changed. In 1921, thirty-five city blocks of Greenwood were burned to the ground, and 300 people were killed and 800 injured at the hands of white mobs.[57] Similar episodes of destruction of other prosperous Black communities extended from Tulsa to Washington, D.C.[55]

The 20th Century

The zeitgeist of the first half of the 20th century was one of tolerance for the racial terrorism and legalized exclusion of Black Americans from significant participation in the economy, in other aspects of society, recreation and the politics of the United States. It was essentially a U.S version of apartheid, which, though most intensely applied in the southern states, actually carried an impact in all aspects of American life.

The original construct of Social Security excluded domestic and agricultural workers, an exclusion that disproportionately affected Black Americans.[58] Following World War II, federal mortgage lending programs helped white Americans buy homes building generational wealth, while having policy that stated the presence of a Black resident in the neighborhood reduced the value of the homes in that neighborhood.[59,60,61]

Black people faced social, professional, commercial, and legal discrimination. Laws were enacted to support a segregated social structure based on race. Theaters, hotels, and restaurants segregated Black people in inferior accommodations or refused to admit them at all. Shops served them last.[62] Hospitals usually had segregated wards if they admitted Black patients.[63] People who fought against these rules were jailed or worse.[64,65] The models of segregation in the United States were so effective they were ultimately used by Hitler and served as a basis for the construction of apartheid.[66,67,68] Segregation of accommodations - not just in the south, but also in places now considered progressive like San Diego and New York - made travel difficult for Black people. In 1937, The Negro Motorist Green Book, a travel guide, was first published. It listed establishments where Black travelers could expect to receive unprejudiced service.[69] Segregated public schools meant generations of Black children often received an education inferior to that of white children—with worn-out or outdated books, underpaid teachers, and lesser facilities and materials.[70]

Oregon Was No Exception

Slavery in the Oregon Territory was prohibited in 1843; however, Black Exclusion Laws which were first enacted in 1844 attempted to prevent Black people from settling within the borders of the territory and eventual state of Oregon. In 1859, Oregon became the only state admitted to the union with a Black Exclusion Law.[71] Black Exclusion Laws legalized public whippings of Black individuals who entered Oregon until the penalties were later changed to force Black individuals into physical labor instead. White individuals who settled on Native land in what is now the state of Oregon further benefited from the 1840 Donation Land Act which provided

white citizens with free land. These laws are a few of the many reasons why there is a lack of overall diversity in the state, a significant racial wealth gap, and related health inequities. Racist laws continued to be made in the territory, including making it illegal for Black residents to own real estate, make contracts, vote, or use the legal system. Oregon also banned interracial marriage, a law which was not repealed until 1951. The 1857 exclusion law remained in the Oregon Constitution until 1926 when it was repealed by a ballot measure. The Fifteenth Amendment, ruling that Black Citizens could vote, was passed by Congress in 1869. The Amendment was rejected by Oregon in 1870 and not ratified in the state until 1959, 90 years after adoption in the United States.[72]

The 1920s saw a resurgence of white supremacy with the KKK in Oregon also. In 1923, the Oregon Chapter of the Ku Klux Klan had 35,000 members. The Oregon KKK was a mainly anti-Catholic organization as the Asian American and Black populations in the state were not large enough to mount a significant campaign against racial minorities. The Klan collapsed by 1925, with exception of the Tillamook branch, which lasted through 1928.[73] Black Exclusion was repealed in 1926, but its impact is long lasting.[74,75] The racist language in the Oregon State Constitution persisted for several decades more. The last vestige of racist language was finally removed from the Oregon State Constitution in 2002, just six years before Barack Obama became the nation's first Black president.[71]

Although the 14th Amendment was ratified in 1868, conferring equal protection under the law for all citizens and affirming that Black people are full and equal citizens, interpretation by the Supreme Court was restrictive until the second half of the 20th century. Segregation was made legal through the Plessy v. Ferguson decision (see above), thus allowing continued disruption of Black neighborhoods and enterprise through land use rules and other laws and covenants, contributing to a cycle of poverty.[76] Oregon has its own examples of this in the displacement of Black people from their homes during the expansion plan for Legacy Emanuel in 1970, which is discussed in more detail below.

Dr. DeNorval Unthank (December 14, 1899 - September 20, 1977) was a Black physician who moved to Portland in 1929. He and his family settled in the all-white neighborhood of Westmoreland, but they were violently harassed. Their house was pelted with rocks, and ultimately, they were driven from their home. They were forced to move four times before being able to settle. Dr. Unthank was not allowed privileges in any Oregon Hospital and delivered babies in his home. He took care of many thousands of patients of all races. He was the only Black physician in Portland in the 1930s. He became the first Black member of the City Club of Portland in 1943. He founded the Urban League of Portland in 1945 and served as president of the Portland NAACP chapter. There is a park named after him in the Boise neighborhood.[77,78]
In Portland, the Albina neighborhood was the only area in Portland where Black individuals could own a house as a result of racist codes put in place by the Realty Board of Portland.[75] In 1948, the "National Realtor Code" permitted Oregon realtors to deny homes to individuals "of any race or nationality whose presence will be detrimental to property values".[79] The Oregon Fair Housing Act was passed in 1957; however, the discriminatory denial of loans in the form of redlining continued in Portland during the 1970s and 1980s, further preventing minority citizens from owning property throughout the city.[75] The gentrification of North Portland began in the late 1980s and continues to this day, with many Black individuals and families forced to move as a result of rising housing prices in this historically Black community.

Medicine Was Not Exempt

Professional medical organizations, hospitals, and medical schools were not exempt from these discriminatory practices.[80,81] Rather than leading society away from tolerating racial exclusion, they followed the path of the country. The American Medical Association's (AMA) policy of tolerating racial exclusion by its member organizations was pivotal in contributing to a two-tier system of medicine in this country.[80,82]

Previously admitting only white physicians, the AMA later opened its membership to people of color but did not acknowledge past harms done to Black physicians and their families and patients until 2008, when AMA Immediate Past President Ronald Davis met with the National Medical Association (NMA), an organization for Black physicians, in Atlanta, offering a formal apology. Racial exclusion has many downstream effects and "the medical profession, which is based on a boundless respect for human life, had an obligation to lead society away from disrespect of so many lives."[82]

A direct line can be drawn between acceptance of white supremacy and segregation to the Flexner report and then to the subsequent racial divide in medicine. The 1910 Flexner report on medical schools examined medical school entrance requirements, the size of endowment and tuition, the size of laboratories, and the availability of teaching hospitals and their clinical teaching staff in order to standardize admission requirements and design medical school curriculum to include both basic science and clinical exposure.[83] A direct result of this report and subsequent changes in medical programs led to the closure of 5 of 7 then-extant Black medical schools.[84,85] Flexner's conclusion that these Black medical schools were "in no position to make any contribution of value"[86] further exacerbated their chronic funding challenges and resulted in the subsequent erasure of up to 35,000 Black physicians from the hallways of United States hospitals who could otherwise have been trained at these five-medical schools from the time they closed to the year 2019.[87]

To the Present, With Some Conclusions

The conditions of the postbellum period were made insufferable for Black people through incessant, cruel, racist attacks against their very existence and the forceful removal of any pathways for improvement of their situation. According to economists Robert Williams Fogel and Stanley L. Engerman in their book, *Time on the Cross*, "...the life expectations of Black people declined by 10 percent between the last quarter century of the antebellum era and the last two decades of the nineteenth century. The diet of Black people deteriorated. Studies of the diet of Black sharecroppers in the mid-1890s indicate that they were protein and vitamin starved. The health of Black people deteriorated. Sickness rates in the 1890s were 20 percent higher than on slave plantations. The skill composition of the Black labor force deteriorated. Blacks were squeezed out of some crafts in which they had been heavily represented during the slave era and were prevented from entering the new crafts that arose with the changing technology of the last half of the nineteenth century and the first half of the twentieth. The gap between wage payments to Black and white workers in comparable occupations increased steadily from the immediate post-Civil War decades down to the eve of World War II."[88]

Apart from racism, the basis of these attacks, at least in part, was due to the fear that this four-million strong workforce, much of which was skilled in crafts ranging from carpentry, blacksmithing, coopering and metal works, to farming, pottery, tool making, and production of clothing, would be strongly competitive in the marketplace. The choice of Black labor during slavery was not just because it was free, but because slaves were hardworking, efficient, and capable. The threat of workforce competition from Black people was virtually eliminated through restrictions on land ownership, licensure laws, and education. Taxes and fiscal policies were

used to transfer income from Blacks to whites which made it impossible to accumulate wealth and invest in the future.[88,89]

The laws supporting Jim Crow, segregation and the resulting racist societal structure were actively challenged by civil rights advocates including the legal team of the NAACP, an organization which was formed in 1909 for this very purpose.[90] These laws began to topple in 1948 with Truman's Executive Order 9981, desegregating the military.[91] In 1954, the Supreme Court declared discrimination in education unconstitutional in Brown v. Board of Education of Topeka, but it would take another ten years for Congress to restore full civil rights to minorities, including protections for the right to vote.[30]

Racist language was removed and replaced within state and federal legislation over the next 20 to 30 years, making school, job, hotel accommodations, hospital, restaurant, and institutional segregation illegal.[92,93] Discriminatory real estate and hiring practices were outlawed,[30] but discriminatory practices still exist, and consistent enforcement of these laws is still needed today.[94]

In the early to mid-1960s, Black communities, frustrated with the effects of systemic racism, including unfair policing policies, biased justice system, poor or inadequate housing, poor public education, high unemployment rates, voter suppression, and various forms of discrimination, erupted in riots across the nation.[95,96] Many newspapers at the time propagated a view based on racism, blaming the riots on Black people and "Black anger".[96] However, the 1967 presidentially appointed Kerner Commission concluded that white racism, not Black anger, was at the root of the violence.[96]

A tremendous amount of effort was needed to create and sustain systemic racism. Over the years, Jim Crow was finally overcome by way of a long and arduous struggle culminating with the civil rights protests of the 1960s. Legal segregation was shown to be in conflict with the constitution and its amendments. However, this recognition de jure, does not imply that racism has been excised de facto from our institutions and structures.[97] Unravelling the effects of slavery and systemic racism will continue to take a tremendous amount of effort, courage, and focused cooperative intention. The long-term impact of living under a system of oppression is significant, and newer challenges have evolved.

Effects of Racial Bias in Society

In the remaining sections we discuss the scope and complexity of the present situation. We will show that segregation and discrimination continue in our society and its institutions. Racism is robustly embedded in our social structures, having been created and supported by the history described above. Ultimately, disparities in health and outcomes result. Control over the imagery and story of a people impacts their ability to take control of and mold their future. Ideas of racial superiority have been used to rationalize the brutal treatment of other human beings.[98] In order to justify slavery, white slave traders, owners and enablers had to depict and view Black people as "other" or "less than." Today there are many examples of the perpetuation of this narrative of racial inferiority, with devastating outcomes.[99]

TS, a 41-year-old Black woman who worked as a supervisor of social services in San Francisco, had a history of breast cancer in remission. She went to the emergency room with severe chest pain. EKG and lab work were unremarkable. She was seen by the ER doctor. Her concerned husband, a tall, muscular Black man, was with her. Her care team concluded that perhaps her husband was beating her, and that she might have a broken rib. Social work was called.

Ultimately, she was sent home and told to take Tylenol. She returned a few times with the same pain, now worsening, but the results did not change. A few months later, another ER doctor saw that the history of breast cancer had been listed and ordered a CT-scan of the chest that revealed large metastases invading the sternum. The patient later died. (Stories like this one are shared and known within affected communities, impacting the community who is targeted and further contributing to distrust, but often lost to general knowledge by the public. This story was shared by a contributing member of the OMA Equity Task Force.)

A clinician's assumptions have a direct impact on care. The racially biased assumptions in TS's case delayed her diagnosis and negatively impacted her care. While explicit bias (a.k.a. bigotry) has declined in the past 50 years and is now considered unacceptable in general society, implicit or unconscious bias is common and persistent.[100] It is found in our health system still today, and can prevent people of color from receiving adequate, equitable care or benefitting from access to care.[101] There is evidence that implicit bias results in disparities in treatment recommendations, expectations of therapeutic bonds, pain management, and empathy.[102] Stories like the one above, shared within the community, underpin expectations of biased care, and impact the trust and bias that patients bring with them to a clinical encounter.

Such implicit bias occurs as a result of stereotypes and prejudices, and in medicine, this bias can cause a difference in care and treatment based on a patient's race, age, gender, weight, or other physical characteristics. In 1998, Project Implicit was founded and Implicit Association Tests (IATs) were created and made publicly available.[103] These tests attempt to measure the often-unspoken attitudes or beliefs of individuals and educate test takers on their personal implicit biases. IATs are commonly used by medical schools and healthcare institutions to increase bias awareness. A 2015 systematic review of IAT results amongst healthcare providers found low to moderate levels of implicit racial/ethnic bias and identified a resulting impact on the patient-provider interaction, treatment decisions, treatment adherence, and patient health outcomes.[101] However, the test alone has not always been shown to identify or reduce implicit biases and it is recommended that these tests be paired with other training.[104]
As a field, health care must move beyond IAT training and start incorporating training based in critical race theory in order to address systemic racism in our institutions. Critical race theory was created and promoted by civil rights scholars to address the root causes of racism including societal structures and cultural assumptions. It incorporates race consciousness, societal dynamics, and centers the perspective of socially marginalized groups.[105] Critical race theory is already being used in many fields, including public health, to address racial health inequities.

Effects of Bias Outside Health Care

Bias against people of color starts outside the field of health care. Stereotypes of Black people have evolved over the years, always serving the best interests of their creators. The enslaver who used violence to compel slaves to work needed justification for this behavior. Black people were depicted as docile and lazy -- the "Sambo" stereotype. White society embraced this notion which could assuage guilt about slavery as it seemed to follow that Black people needed the direction of the slave master.[106] After slavery ended and Black people began seeking independent existence, whites engaged in the violent suppression of these aspirations. The white portrayal of Black men shifted to that of the "brute savage." This was meant to justify the ferocious attacks and lynchings of Black people and to support segregation. 1915 saw the release of "The Birth of a Nation," a film that depicted the Ku Klux Klan as heroic and honorable, depicted Black men as savages attacking white women, and paved the way for the racist narrative that continues to paint Black men as dangerous and predatory to this day.[106]

More recently, American media (which is largely owned and controlled by whites) has contributed to and continues to contribute to Black criminal imagery through subtle use of words, pictures, videos, and entertainment that suggest that Black people tend toward criminality. This kind of subliminally suggestive programming is particularly harmful because people are unaware of it. Without realizing the racist undertones, a white person might call the police because a Black person is walking down the street in their predominantly white neighborhood. They might cross the street or grab their purse or wallet more tightly when a Black person approaches. The person may not even be aware of these actions. But this kind of thinking, fueled by bias, can be dangerous, especially when it influences how individuals and institutions—especially the police—interact with Black people.[107,108,109]

Paul Butler is a law professor at Georgetown University Law Center and is author of the book *Chokehold* where he writes, “The bottom line is that it is not crazy or racist for a person to think she is more likely to be the victim of a street crime perpetrated by an African American man than a man of another race. It is just that it is unlikely that either event will occur. The person who is at most risk from a Black man is another Black man, and even this risk is relatively low. For the most serious crimes—homicide and rape—whites are much more likely to be victimized by white people they know than by Black strangers.”[110]

Negative stereotypes that dehumanize and degrade a group of people can be internalized and the dominant group ideology accepted as deserved and inevitable, causing additional harm by precipitating poor self-concept.[111] When Black children internalize negative stereotypes about themselves, it affects school performance which in turn impacts the work and socioeconomic opportunities and the communities they live in later.[99]

These societal biases also influence judicial sentencing patterns. Jennifer Eberhardt, Stanford Professor of Social Psychology and McArthur Award recipient, conducted a study that found that “suspects with stereotypical African features have tougher jury verdicts, longer prison and death sentences, and a greater probability of mistaken identity.”[112] Pamela Newkirk commented on these findings and others in her book “Diversity Inc: The Fight for Racial Equality in the Workplace,” observing, “The problematic perception of Black barbarity mirrored in mass-media representations then becomes a self-fulfilling reality that serves to normalize the hyper-criminalization of Black people in society.” As Newkirk explains, biased portrayals of Black people in the media have real-world repercussions and serve to disadvantage Black people in many areas of society, perhaps most notably within the criminal justice system.[112]

The struggle to coexist with the constant existential threat of the negative imagery mentioned above is not unique to Black men. Black women have also fought to maintain their individual identities in the face of pejorative images since the advent of slavery over 200 years ago.[106] Data show that the majority of women on welfare, such as SNAP (Supplemental Nutrition Assistance Program) are white, though the label of “Welfare Queen” has been effectively attached to Black women through the voices of media and politicians.[106,113,114] The use of the label “Angry Black Woman” is particularly damaging as it is often used with women in important positions to demean them and devalue their opinions when they speak up about injustice in the workplace.[115] Former President Trump applied this term to Vice President Kamala Harris because of her intense questioning of Supreme Court Justice Brett Kavanaugh during his confirmation hearing.[116]

The prevalence of this imagery that has populated American media for centuries have served to minimize the worth and ridicule the plight of Black men and women, impacting

their own and others' attempts to combat racial injustice. When these narratives influence how individuals and institutions interact with Black people, it increases their negative impact.[115] Such stereotypes also influence political and legislative decisions.[106,115,117] For example, most crack users were and still are white, but sensationalized media depictions of "crack whores," "crack babies" and violent "crackheads," were portrayed as primarily Black. These were effective in recruiting political support and steering the War on Drugs into communities of color.[118,119,120] **The consequences are evident in policy and enforcement; in particular, differences in law enforcement practices have a significant impact on communities of color.**

Discrimination in Decision-making and Outcomes in Oregon

A real-world example of the repercussions of housing discrimination is found in the story of the Vanport community. The Vanport community was a 1942 WWII temporary housing project that became a majority Black community as a result of discriminatory housing policies. Despite rising water levels due to heavy rainfall in 1948, residents of Vanport were not warned that the neighborhood was at high risk of flooding and the dikes were failing. When the region flooded, it resulted in the death and abrupt displacement of thousands of Black Oregonians. It was already difficult to find a home as a Black Oregonian and the only option for Black families at this time was to move to the overcrowded Albina District.[121] These Black families then experienced further displacement due to the expansion of Legacy Emanuel Hospital in later years.

It is clear that Oregon has been no haven from individual and systemic examples of racial discrimination. Examples are seen in employment, schooling, housing, welfare, recreation, and policing; this was recognized fifty years ago by the City Club of Portland.[122]

The City Club arrived at the conclusion that city government engaged in projects and made policy decisions that neglected the input of affected citizens when Black neighborhoods were involved. The gentrification of North Portland in the 1970s is a good example of this governmental neglect and lack of citizen input.[123] Many Black people were displaced when white city leaders pushed through major plans without making effective attempts to communicate with the people living in the impacted neighborhood. The expansion of Emanuel Hospital in 1972 led to the destruction of 22 city blocks containing between 200 and 300 homes and businesses in the primarily Black neighborhood of Albina. The owners were reimbursed far below market value for their property. People with limited resources were displaced. Homes were capriciously demolished, despite the fact that Congress ultimately failed to fund the entire project. Tragically, there are still vacant lots around the hospital and much of this land remains empty.[124,125,126] The consequences are clearly devastating and long lasting when systems are set up and decisions are made without inclusion of those directly impacted.

Exclusion from power and minimizing the voices of the people impacted has a direct impact on the well-being of the community. In the United States, economic disparities are ongoing: median household income for Black Americans is about $46,000, compared to $63,000 for white people. Home ownership is a major source of wealth and savings, but just a third of Black people own their homes, half the rate of white people. Black people still find it more difficult to get loans.[127,128]

The schools in Portland, Oregon, remain relatively segregated. Black high school students are twice as likely to be expelled or suspended. Sixty-eight percent of Black students graduate from high school on time, as compared to 85 percent of white students. Black/white performance in school is fairly even initially for math and science, but the gap widens over time. Of Black 10th

grade students, 60 percent do not meet reading standards, 75 percent do not meet math standards, and 63 percent do not meet writing standards. Black people with four-year college degrees make $11,000 less than their white counterparts.[129]

The problems Black Oregonians have faced parallel what Black Americans have experienced elsewhere in the United States. **Generations of life under systemic racism have impacted the resources, self-image, and opportunities of Black Americans, and made the cycle of poverty more difficult to break. The small number of Black people in Oregon makes it difficult for Black Oregonians to reclaim and redirect their own stories or change the imagery that promotes bias and continues to have real, lasting consequences.**

Public Health Issue No.1: Law Enforcement in the Black Community and the Disproportionate Loss of Black Lives to Violence

On May 25th, 2020, George Floyd, a 46-year-old Black man, was arrested for alleged use of a counterfeit $20 bill and killed by a police officer. Several video recordings detailed the incident.[130] He was handcuffed and was lying face down. He presented no threat to officers or bystanders. Other police officers stood by without intervening. Onlookers appeared helpless to do more than protest and express their distress as events unfolded.[130]

Following this event, ongoing protests erupted across the United States and worldwide.[131] The tragic episode of George Floyd's death is evidence that systemic racism, the motivation behind the March on Washington nearly six decades ago, continues to be a problem today.

Police Violence in the Black Community

The killing of George Floyd is not an isolated event. The probability of extrajudicial killing of Black citizens by law enforcement is 2.5 times that of white people. Hispanic men are also disproportionately impacted with a rate nearly two times that of white men.[132] **Black men face a one in 1,000 risk of dying at the hands of a police officer in their lifetimes.**[133] For white men, the risk is lowest at 39 per 100,000.[133]

Loss of life due to police shootings in this country occurs at a relatively constant rate of about 1,000 citizens per year.[132] This is a very high rate compared with the rest of the world, and it affects all races.[134] For perspective, in England and Wales (with a population of 56.9 million) there were 55 fatal police shootings in the last 24 years. In the United States (with 316.1 million people) there were 59 fatal police shootings in the first 24 days of 2015.[135] The vast majority of police officers in the United Kingdom do not carry firearms, so this may be viewed as an unfair comparison. That said, it is a comparison that emphasizes there are other effective ways to police that are less deadly to citizens. Differences in law enforcement tactics are likely tied to the UK's laws limiting the availability of firearms.[136]

Gun violence occurs in significant frequency in our society, and a significant number of the police killings may be arguably justified individually on the basis of self-preservation and protection of others. This raises the question: how dangerous is it to be a police officer?

When examined statistically, policing has become a safer profession over the last five decades. Prior to 1980, an average of 115 police officers per year were killed feloniously (killed as a result of a criminal act) in the line of duty. From 2006 to 2015, the annual average number of felonious police deaths was 49.6.[137] Between 1970 and 2016, the number of line-of-duty deaths has fallen by 75 percent.[138] The number of police officers has increased over time and there are about a quarter of a million more officers working today than there were three decades ago.[137] Despite

declines in death rates, policing remains a risky profession. Between 2014 and 2019, 1,467 law enforcement officers were shot with 249 fatalities (245 shot per year with 42 deaths per year on average).[138]

In summary, there has been a significant drop in the number of police officers killed in the line of duty. While each one of these is tragic, the numbers do not seem to be consistent with the high and nearly constant rate of civilian fatality at the hands of the police. Furthermore, it does not explain the divergently higher rate of police killings of Black and Hispanic people.

In 2015, the number of citizens killed by the police was 994; 94 of which were unarmed. Of the unarmed people killed by police, 38 were Black, and 10 were suffering from mental illness. The incidence of fatal encounters was 18.6 per million and 1.7 per 100,000 for unarmed persons overall. The incidence of fatal encounters for unarmed Black men was 6.1 per million, while that for Hispanic men was 2.8 per million and white men was 0.9 per million. The killing of unarmed Black people at the hands of the police is 7 times the rate for white people.[132] Police use of force is a leading cause of death for Black men in their mid-to-late 20s, and while this risk is highest for Black men it is measurably elevated for Black women and other people of color as well[139]

In 2015, an estimated 53.5 million (about one in five) persons aged 16 or older experienced some kind of contact with the police during the previous 12 months.[140] In citizen-initiated contacts, the police were felt to have improved the situation in the majority, and this was true for white, Black, and Hispanic subgroups independently. Close to 90 percent of each of these subgroups were more or as likely to contact the police again. However, approximately 2 percent or 1 million people experienced nonfatal threats or use of force from a police officer. Men were about three times more likely than women and Black and Hispanic people were about three times more likely than white people to experience this.[140]

Lloyd Stevenson was a 31-year-old off-duty security guard, father to five, and a former Marine. He was in a 7-Eleven store in Northeast Portland when it was robbed in April of 1985. He helped the employees stop the thief, but then got into a fight with a witness in the parking lot. A police officer put him in a "sleeper hold." Stevenson was pronounced dead 45 minutes later at a Portland hospital.[141] An inquest jury reached a verdict that the cause of death was criminally negligent homicide, but a grand jury refused to bring indictments against any of the officers.[141]
When law enforcement officers enter a neighborhood in which they perceive a higher threat of violent crime or higher density of firearms, they might carry a higher level of anticipation and suspicion. Researchers have explored and identified racial bias in decisions to use deadly force. Black Americans are more likely to be perceived as dangerous and warranting such a response.[142,143,144] In a racially segregated Black neighborhood, if an officer anticipates a higher threat level, it may blur the lines between suspects and innocents; this can also contribute to perceptual distortions as events unfold.[145,146,147]

In law enforcement training, officers are taught to prioritize victims and innocent bystanders over themselves. On the other hand, the perpetrator's life is of lesser concern than the lives of the officers.[148] Law enforcement professionals are also taught about perception time and reaction time. Reaction time is perception time plus action time. Perception time is that time needed to discern a threat. Action time is the time it takes to raise a weapon and fire after a threat is realized.[149]

Reaction time is therefore always greater than action time, generally putting officers at risk in violent situations. In practice, environmental factors weigh in, such as distorted light with

shadows and reflections, noise, weather conditions, etc. Officers may seek to eliminate the action time, and simply be ready to act preemptively. Reaction time experiments demonstrate that a police officer encountering an armed suspect, even when their own gun is ready and aimed at the suspect, will not be able to fire faster than a suspect who initiates action and chooses to shoot the officer.[150]

These factors complicate the interaction of police officers with suspects. Anticipation, in a situation which is perceived to be dangerous, can be lifesaving. But this puts the suspect, who is presumed innocent until proven guilty, at potentially higher risk. When this risk is multiplied by a large number of similar interactions, this risk approaches reality.

A history of poor interaction between a neighborhood and law enforcement may lead to some defiance on the part of the neighborhood's citizens, which can intensify the anxiety and tension on the part of the officer. The interactions between officers and citizens can be quite complex under these circumstances.[151,152]

Confrontational policing tactics, such as "Stop, Question, and Frisk" (SQF) and racial profiling, have additional social cost and further erode trust in agents of law enforcement.[153] Such tactics reduce the sense of safety within the targeted population; incidents of police brutality (experienced directly or indirectly) can contribute to trauma and PTSD.[99] New York City's SQF tactics in 2002-2013 resulted in nearly 5 million stops. No arrest was made in 88.1 percent of these stops. There were large differences across demographic groups in their experience of innocent stops with almost 25 percent of all stops targeting Black men aged 14-24 years, despite this group representing only 1.9 percent of the city's population. "Proactive" policing tactics hence perpetuate significant differences in perception of policing with 77.6 percent of whites reporting that "police behaved properly" in their interactions, whereas for Blacks, the percentage was only 37.7 percent.[153] Law enforcement officers' expectations and biases, and the lack of trust of Black citizens when interacting with police, may contribute to rapid escalation and physical aggression or violence in these interactions.

Policing and the Crime Rate in the Black Community

In one narrative that attempts to justify the high level of police violence against Black Americans, it is suggested that the increased mortality rate for Black people at the hands of the police is due to higher police presence leading to increased contact, which in turn is related to higher crime rates in Black communities.[154] This may be a logical argument; however, it begs the question of why the higher police presence and increased numbers of contacts with the members of the Black community is not producing a lower crime rate.

Black people account for close to half the country's homicide victims despite representing only 13.4 percent of the population.[155] Black Americans are six times more likely to be murdered than are white Americans.[156] For young Black men this disparity is even greater, with Black boys and men between the ages of 15 and 34 experiencing homicide rates 15 times those of white boys and men of the same age.[156] **Homicide is the second-most important contributor to the racial gap in life expectancy. If this discrepancy were eliminated, it would do more to equalize life expectancy by race than the elimination of death by any other cause except only cardiovascular disease.**[156]

Interpersonal violence is a major cause of death and disability among young Black men.[157] In the age group of 1-19 years, homicide is the leading cause of death for Black males, at 35.2 percent. It is also the leading cause of death for Black men ages 20 to 44, at 28.9 percent.[132]

Unfortunately, this risk especially impacts people at a time in their lives when education and productivity is most important, contributing to the significant toll that violent death and injury take on the community. Deaths at the hands of police cause additional harm with resultant spillover effects in these communities, including on mental health.[158]

Lack of police presence in Black neighborhoods is not the problem. Black communities are simultaneously "over-policed" and underserved by police. The disproportionate use of SQF (described above), Special Weapons and Tactics (SWAT) teams to carry out drug arrests, and the use of no-knock warrants (which will be described later), all represent "proactive" or confrontational policing tactics that are oppressive to all members of the community, including those not involved in criminal activity.[159] At the same time these tactics can actually contribute to lower clearance rates (identification and removal of perpetrators) for homicide, leading to these killers acting with impunity, and greater preemptive killing in the community to protect self and family.[160] This style of confrontational policing also creates a rift and an atmosphere of distrust, reducing community members' willingness to cooperate with the police and making it difficult to find witnesses, prosecute perpetrators, and clear dangerous criminals. The dilemma is clear: ineffective policing leaves members of the community in danger which results in justified fears of retaliation for cooperating with the police. This further prevents those who might be willing to bear witness and perpetuates deficiencies in policing outcomes.

Focusing on the crime levels in Black neighborhoods as a cause for increased police presence and contact deflects attention from the core issue of how these neighborhoods have developed higher crime rates and maintained them despite that police presence. Poverty and joblessness (exacerbated by high incarceration rates and its impact on employability) have led to crime as an alternate pathway for survival. Brendan O'Flaherty and Rajiv Sethi, Professors of Economics at Barnard College and Columbia University respectively, report in their book, *Shadows of Doubt*, that criminal activities are secured by more criminal activity, which can lead to murder. Murder rates are exacerbated by fear of murder in an atmosphere where killers have impunity from the law.[160] If the policing goal is serving and protecting, then this form of policing is a predictable failure. It has been debated whether increasing police presence is effective at reducing crime. While community style policing (in which the police embed themselves in the neighborhood, walk the beat, and get to know neighborhood residents) might help to deter crime,[161] a large body of evidence supports a greater need for global investment in communities to improve public safety.[162,163]

In another narrative that attempts to justify the high level of police violence against Black Americans, it has been argued that in regions of higher gun violence police will tend to be faster to draw and use their weapons.[164] This again oversimplifies the problem and distracts from the reasons behind the high levels of gun violence. The argument ignores the role of America's lack of legislated restrictions on firearms in contributing to the heightened risk of police killings in this country[165,166] and absolves the police of their role in racialization of poor law enforcement outcomes. At its worst, this argument appears to place the blame on the people living and dying in these communities for the circumstances contributing to violence within the communities which include residential segregation, higher incarceration rates, lower educational attainment, poor economic indicators and employment status.[167] The risk of death from police interactions is higher for Black citizens compared with white citizens presumably because of underlying bias towards Black people and Black communities.[142,143,144,167,168,169] Addressing bias in law enforcement must be a part of the solution, but correcting the upstream systemic social and economic contributors is also necessary to reduce violence within a community.

Communities that lack economic opportunity and access to resources foster opportunities for criminal activity to arise, and protection of this activity is done violently, creating “hotspots” of crime.[170] In his book, *A Great American City*, urban sociologist Robert Sampson notes that “even though the city of Stockholm has far less violence, segregation, and inequality than the city of Chicago, in both cities a disproportionate number of homicides occur in a very small number of very disadvantaged neighborhoods.”[171] This implies that the criminal activities of a relatively small subgroup can raise the risks for those living in the vicinity of one of these hotspots. Significant regional variation of the homicide rate is noted between states, with the highest three being Missouri at 46.21, Wisconsin at 37.57 and West Virginia at 36.86 per 100,000 in 2016. The lowest three states that year were South Dakota, Vermont, and Montana all of which had rates of 0.[172] Oregon sat at 8.02 per 100,000. Violent Crime has been shown to be localized to geographic hot spots which are mostly urban locations.[173,174]

In her book, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*, Michelle Alexander, writer, civil rights lawyer, opinion columnist for The New York Times, and visiting professor at Union Theological Seminary, offers the following explanation for violence within Black communities: "What a growing number of sociologists have found ought to be common sense: by locking millions of people out of the mainstream legal economy, by making it difficult or impossible for people to find housing or feed themselves, and by destroying familial bonds by warehousing millions [in prison] for minor crimes, we make crime more—not less—likely in the most vulnerable communities.... When given a choice, most people in the ghetto, like anywhere else, would prefer to be able to work, support their families, and live without fear of harm or violence, if given the chance.”[118] Seeking to control this violence with increased police presence does not correct the source of the problem and can contribute to the risk that police presence might add to the already high rates of violent death within the community.[156,159,160,175]

<u>Violence as an Outcome</u>

Identifying all the root causes of violent crime is challenging. The list includes poverty; segregation with inequality; joblessness; residential instability, foreclosures, vacancy rates, and evictions; and land use issues. In the Black community, these are the result of a long history of systemic racism. Not surprisingly, communities with effective policing, strong social organization, job opportunities, access to resources to solve community problems, and residential stability have lower rates of violent crime.[170]

Violence represents a public health issue for people of color.[176] The stunning statistics demonstrate that homicide is the leading cause of death in Black men between the ages of 1 and 44. Police use of force contributes to risk of death for Black people, but this problem cannot be viewed in isolation. Despite the increased police presence in Black neighborhoods, the lack of effective policing leaves criminals unhindered and contributes to an insecure environment. Confrontational policing tactics broadly targeting Black citizens and policies focused on controlling, rather than healing or protecting the community, contribute to risks of violence. To eliminate violence, policing must engage the community and evolve to effectively combat crime. At the same time effort must be directed at transforming social and political policy to promote an environment of wellbeing for these communities.[173]

Public Health Issue No. 2: The War on Drugs

Just two months prior to the death of George Floyd, Breonna Taylor, a 26-year-old emergency medical technician, was killed when three Louisville Metro Police Department officers forced entry into her apartment under the authority of a “no-knock” search warrant for drugs and drug money. Gunfire was exchanged because Taylor’s boyfriend thought someone was breaking into

the apartment. Ms. Taylor, who was unarmed, was shot eight times, and died. No drugs or drug money were found in the apartment.[176]

Public awareness of this event has prompted concern about the policies and procedures that led to Taylor's unnecessary death. Much of the legislation and the associated procedural changes that allowed for this circumstance began after the War on Drugs was officially declared in 1971 by the Nixon administration, and later again in 1982 by the Reagan administration, despite the fact that illegal drug use was actually on the decline.[118] The effect of the War on Drugs was to increase the size and presence of federal drug control agencies, start mandatory sentencing, and allow no-knock warrants. Arrests and convictions for drug offenses skyrocketed, especially among people of color.

Politics and Criminalization of Substance Use

Believed to be politically motivated by many, the War on Drugs has ravaged Black and Hispanic communities.[118] John Ehrlichman, Domestic Policy Chief for the Nixon Administration, exposed the administration's intent on using the War on Drugs to harm the Black community: "You understand what I'm saying? We knew we couldn't make it illegal to be either against the [Vietnam] war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin—and then criminalizing them both heavily—we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did."

Ultimately, incarceration of people who are caught in possession of drugs demonstrates indifference to the possibility of an underlying substance use disorder. The laws do not adequately account for the medical situation. The unanswered question at the root of mass incarceration concerns our definition of crime and further stigmatization of substance use for political gain. Incarceration of people with substance use disorder does not improve their access to appropriate and needed medical care and inflicts people with the permanent label of convicted felon. Formerly incarcerated people with substance use disorder, which may be untreated or undertreated during incarceration, have a very high incidence of accidental overdose on returning to the community.**[177]** At the time of reentry into society, stress, lack of support, poor access to healthcare, and difficulty finding work (often a consequence of their conviction history), heightens the risk of relapse into drug use, re-incarceration, overdose, and death.**[178]** Investment in mental health and substance use disorder services during and after incarceration has been shown to help break the cycle of re-incarceration by reducing relapse into drug use.[179]

Further complicating this situation are mandatory minimum sentences which eliminate a judge's ability to apply discretion and have forced judges to harshly punish nonviolent drug offenders despite the low risk of physical danger to the community. This rapidly increased the prison population after the 1984 Sentencing Reform Act.[180] The impact has been both direct, through mass incarceration, and also indirect, through the impact on family members and bystanders.

No-knock warrants result in forced-entry, military-style police raids on individual homes and apartments.[181] These raids have had a terrible impact on entire neighborhoods. Forty-two percent of SWAT team raids targeted Black people and twelve percent targeted Hispanic people. Sixty-one percent of all the people impacted by SWAT raids in drug cases were minorities. Stark, often extreme, racial disparities in the use of SWAT for search warrants were found when the issue was studied by the American Civil Liberties Union. These raids result in

property damage and often use violent tactics and equipment that unnecessarily risk bodily harm and death. SWAT teams have been deployed despite the presence of children in the home.[182] Errors have been made and the homes of innocent people raided. Such a mistake was made in the case of Breonna Taylor. Although there is currently no community oversight and collection of data, it is believed that no-knock raids occur at least 20,000 times per year.[183]

Militarization of Law Enforcement

Policing in Black urban neighborhoods has often been confrontational, but after the militarization of the police with the War on Drugs since the early 1980s, paramilitary tactics and high-grade military weapons started to be used to conduct domestic criminal investigations in searches of people's homes, an approach similar to those of an occupying army. The weapons are provided to local and state police agencies through programs such as the 1033 Program, launched in the 1990s, which authorizes the U.S. Department of Defense to transfer military equipment to law enforcement agencies. Additional funding is provided through programs such as the Edward Byrne Memorial Justice Assistance Grant, established in 1988, which provides funding to enforce drug laws. This funding is used to purchase numerous types of weapons.[182]

Drug possession, an activity that can be viewed as victimless or nonviolent, has been treated like a highly dangerous violent crime. The influx of federal funds was on the order of $15.4 billion into law enforcement in association with the War on Drugs, and the Iraq wars made acquisition of the latest in military surplus available at low cost.[182] Despite white and Black people having similar rates of using and/or selling drugs, the prime focus of the War on Drugs has been on poor vulnerable Black neighborhoods, driven by the focus on crack cocaine rather than the powder cocaine that was more popular in white neighborhoods.[118] In essence, the police may behave like a militarized invasion force, raiding the homes of people or stopping and searching them in the streets, creating the impression of an occupying army with little concern for the inhabitants.[184]

SWAT began in 1964 for the purpose of addressing imminent threats such as riots, hostage situations, barricaded suspects, and active shooter or sniper scenarios.[185,186] In 1975, there were 500 SWAT teams nationwide and they were used sparingly. However, SWAT teams have now increased by 15,000 percent, with 80 percent of their activity devoted to executing search warrants, many of which are "no knock" warrants, often for small amounts of drugs.[187,188] This activity does not directly curb violent crime. Federal funding and grants are distributed based on enforcement of the War on Drugs. Law enforcement also garners resources from asset seizures resulting from drug related arrests. There is no equivalent incentive encouraging the investigation of murder and/or robbery to compete with the lucrative incentives provided to police departments by the War on Drugs. This may help to explain why, despite all the police activity, there is still a high murder rate in Black neighborhoods.[184,188,189,190]

The War on Drugs is not a battle with pills on one side and people on the other. From its initiation, it has been a war targeting communities of color, a manifestation of structural racism. The use of the word "war" is appropriate, given the use of military hardware and SWAT teams, in addition to spontaneous unannounced searches that cast a wide net inflicting harm on innocent civilians. The decision to concentrate on "crack" cocaine, most prevalent in the Black community, was deliberate. The criminalization of drug use and possession as opposed to addressing drug dependence with rehabilitation was also intentional. This is in significant contrast to the approach taken toward drug dependence in white communities where rehabilitation is the mainstay.[118,119,120] The impact has been devastating. Although drug use and/or sale by Black people has never been shown to exceed that by whites, law enforcement's

unbalanced attention to the Black community, accompanied by inflexible mandatory sentencing, in a context of bias in court decisions, has resulted in disproportionate conviction rates (detailed in the next section). The impact is not restricted to those currently in prison, but also affects all who pass through prison and carry the label of convicted felon; there are spillover effects on families and friends. **The decision to focus on permanent punishment rather than medical care and rehabilitation for those affected has resulted in tragic consequences, especially for young people just beginning their lives**. This constitutes a public health crisis.

Public Health Issue No. 3: Incarceration Rates and Correctional Institution Health Care

Likely we could point to no better example of systemic racism than the mass incarceration evolving in the wake of the War on Drugs, which led to a massive expansion of Black imprisonment. Presently, 2.3 million people in total are incarcerated in the United States, which is greater both in total number and in percentage of the population than any other country.[191,192] With only five percent of the world's population, 25 percent of the prisoners in the world are in the United States. Between 1970 and 2003, state and federal prison populations grew sevenfold to 1.4 million convicted felons. Offenders in county jails accounted for another 700,000 by 2003. Another 4.7 million people were under probation or parole supervision, so that the correctional population in 2003 was nearly seven million. This accounted for six percent of the adult male population.[193] 450,000 people are incarcerated for nonviolent drug offenses on any given day, and one in five incarcerated people are locked up for a drug offense.[194]

Of 1.5 million drug arrests in the United States in 2016, more than 80 percent were for possession only. Prosecutors are twice as likely to pursue an offence with a mandatory minimum sentence for Black people as for white people arrested for the same offense.[195]

The Black population has been hit especially hard. Black people have been more likely to be imprisoned since the 1920s, when prisons were used to enforce Jim Crow laws. With the declaration of the War on Drugs, special attention to the epidemic of crack, a cheaper form of cocaine, directed policing resources into Black communities, which, due to long years of housing discrimination and poverty, were often concentrated in very localized areas of cities and towns. This siege on Black communities, combined with the removal of judicial discretion in sentencing and the 100:1 disparity of sentencing for crack cocaine as opposed to powder cocaine, tremendously expanded the rate of United States Black male confinement to four times the rate of incarceration of Black men in South Africa under Apartheid.[184]

The three-strikes rule, and other habitual offender laws further exacerbated the problem, such that a person with three nonviolent, victimless offenses could end up with unusually severe punishment of long imprisonment. In October 2020, a Black man in Louisiana was informed by the Louisiana Supreme Court that the life sentence handed down for his last offense (stealing hedge clippers), an offense which followed four prior convictions, had been upheld. He was convicted in 1997 and has been in prison ever since.[196]

Black people represent 13 percent of the United States population, but as of 2020 constitute 35 percent of the municipal jail, state, and federal prison population. This figure represents an improvement, as the Black imprisonment rate dropped by 33 percent over the 12 years from 2006 to 2018. As of 2016, Black people made up 48 percent of the life sentences, 56 percent of sentences of life without parole, and approximately 42 percent of death row inmates.[197] In 2006, Black people were eight times more likely to be incarcerated, on average. The incarceration rate for Black Americans in 2014 had come down to five times that of white Americans.[198] Nationwide, Black children represent 32 percent of children who are arrested, 42

percent of children detained, and 52 percent of children whose cases go to criminal court, while representing only 14 percent of children in the United States.

Oregon follows the national trends with similar statistics. As of August 1, 2020, there are 1,306 Blacks and 9,833 whites in Oregon prisons, out of a total of 13,694 prisoners.[199] With Black people accounting for 9.5 percent of the prison population but only 1.91 percent of the general population of Oregon, this amounts to a Black-to-white incarceration ratio of 5.9.[200] This constitutes a 24 percent improvement compared to 1990.[201] Although Black people in Portland, Oregon are seven percent of the population of the city, 45 percent of Portland's homicide victims are Black. Fully 77 percent of Black youth referrals are adjudicated as compared to 46 percent of white youth referrals.[129]

Formerly incarcerated people often lose the right to vote and have difficulty finding employment, and are denied business loans, student aid, public housing, and other public assistance. One of six Black men between the ages of 25 and 54 have disappeared from typical daily life from either death or incarceration, and one in thirteen Black people of voting age are denied the right to vote because of laws that disenfranchise people with felony convictions.[195]

Health Risks Accompany Incarceration

Incarceration has been associated with premature death. There is increased risk of heart disease, stress-related illness such as psychological problems, hypertension, drug overdose, and cancer among those who are incarcerated.[202] Acquiring infections in prison such as HIV, HCV, tuberculosis, sexually transmitted infections, methicillin-resistant Staphylococcus aureus, and now COVID-19 is also a significant risk.[202,203,204,205] The COVID-19 pandemic has disproportionately affected individuals in United States prisons; they have 5.5 times the case rate and 3.0 times the death rate (adjusted for age and sex) when compared to non-incarcerated United States citizens.[206]

In 1994, voters amended the Oregon Constitution by passing Ballot Measure 17. Also known as the Prison Reform and Inmate Work Act, Measure 17 requires that all able prisoners work 40 hours each week; the legislation also states that 20 of those required hours can be used for unpaid job training.[207,208] In 1999, Oregonians passed additional legislation, in the form of Ballot Measure 68, in order to allow for the creation of Oregon Corrections Enterprises (OCE) under the Department of Corrections to help fulfill the work obligations created by Ballot Measure 17.[209]

The moral argument for divesting from OCE is amplified in light of the COVID-19 pandemic. Prisoners are already at an increased risk of infection as a result of the inability to maintain social distancing in cells or group spaces.[210,211] In addition, many prisons are requiring individuals to make masks and hand sanitizer for the healthcare providers during the pandemic without consistent access to their own protective equipment.[212,213] OCE workers in contact with contaminated laundry from Oregon hospitals may be at an even higher risk for infection. The exploitation of prisoners to handle biohazard material is unethical—especially when the transmission of a novel virus is still being studied. The manager of the OCE laundry plant has also acknowledged that the private sector has automated commercial laundry as a result of COVID-19, which raises further ethical concerns for the direct handling of contaminated laundry from hospital systems.[208] Oregon has had at least one case of COVID-19 in an inmate that worked in a laundry position for OCE.[210] While unstudied, the use of inmates for hospital laundry during the pandemic may be in part responsible for outbreaks within prisons.

As of March 2021, nearly 400,000 people incarcerated in prisons have had COVID-19. Ninety out of the 100 largest outbreaks of COVID-19 in America reported in 2020 took place in jails or prisons. The number of COVID-19 cases has been reported to be 5.5 times higher among people who are incarcerated compared with the general population.[214,215,216] Inmates of the correctional setting do not generally receive health care that meets public health standards, further compounding the risks of adverse outcomes. Health care interventions and prevention efforts in correctional facilities have the potential to directly impact the health outcomes of inmates and the communities to which prisoners return.[202,204]

The Breadth of the Problem and Its Impact

At present incarceration rates, one of every three Black boys born today can expect to be sentenced to prison. This compares to one of every six Hispanics and one out of every 17 white people.[198] Those not graduating from high school are particularly susceptible.[197]

Black and white people use drugs at similar rates, but the imprisonment rate of Black people for drug charges is almost six times that of whites.[198] Mandatory sentencing was applied to crack users in the 1980s through 2000s, but when the more recent opioid epidemic impacted a broader portion of the population (including many white people), it was viewed more as a public health crisis.[217] Additionally, the mandatory sentences for equivalent doses of crack versus powder cocaine are significantly harsher for the form of the drug historically more commonly used in Black communities. Even after this discrepancy was improved with the Fair Sentencing Act in 2010, the ratio remains 18:1 (reduced from 100:1) for sentence length.[218]

Children whose parents are involved in the criminal justice system suffer psychologically and are six times more likely to be involved in criminal activity. One in nine Black children has an incarcerated parent, compared to one in 57 white children, and 2.7 million children are growing up in United States households in which one or more parents are incarcerated. Two-thirds of these parents are incarcerated for nonviolent offences, including many with drug law violations.[219] Partners of incarcerated people often suffer depression and economic hardship.[220]

Our understanding of the health effects of the penal system on individuals, communities, and society is in an early stage, however evidence is emerging in this past pandemic year. **Sociologists and public health researchers have already demonstrated a host of significant adverse outcomes for both incarcerated and formerly incarcerated people and the families and communities to which they belong. This suggests a need for future research and policy development. The adverse effects of the penal system are disproportionately experienced by Black communities and other people of color in this country due to racial differences in law enforcement and justice.**

Public Health Issue No. 4: Race-Based Disparities in Health Outcomes

Background on Race in Health Care

Dr. Esther Choo, an emergency medicine physician in Oregon, said about her interaction with a patient's family: "I told them what was going on quickly and asked if they had any questions. And this is what they said. They told me he worked for [a well-known company]. That he was on his way to work. That he is loved in the community. A good brother and son. That he was well dressed before the blood soaked his clothes. Nothing in recent memory has broken my heart as much as gradually realizing that a family of a shattered man whose chief concerns should have been—when can I see him, when does he get out of surgery, do you know his meds and allergies, his mama gets to go in first—had to worry that the racism inherent in the system and

in people everywhere meant they had to spend their few moments with me putting him in a favorable light, shifting any possible implicit negative frame I had (e.g., "hoodlum" or "criminal") to get him the care he deserved. What is the goal of all our antiracist pledges over the past summer? It's that this family can walk in with full confidence that their loved one is valued and cherished here and that we will fight for his life with everything we have, no questions asked."[221] Dr. Choo's experience illustrates the reasonable fear on the part of many Black Americans that they will not receive equitable or sufficient care from the United States healthcare system, that implicit bias can be assumed to always be a part of care, and that bias must be worked around and minimized as much as possible. This mistrust has been cultivated by centuries of healthcare providers and a system that characterizes race as a biological variable. There is no biological basis for race.[222] Race is a social construct that served at one point in history to distinguish enslaver from enslaved.[223] We must acknowledge that "race" characteristics are a continuum. Health outcomes will improve when we recognize that categorizing patients into a single race serves as a dangerous proxy for biological variation. The belief in biological differences between socially constructed races has served as a catalyst for ongoing inequities in provision of care and abuse at the hands of medical professionals.[220,224]

The historical record provides stories of Black patients being abused by white clinicians. Dr. Marion Sims, the so-called "grandfather of gynecology" performed surgical experiments on unanesthetized Black enslaved women in the mid-1800s. Dr. Sims observed that white women could not tolerate the painful procedures. The enslaved women had no option but to submit to the long, agonizing surgeries.[225] John Brown, an escaped slave, documented his experiences of abuse at the hands of another physician, Dr. Thomas Hamilton, in the mid-1800s. In an attempt to find a cure for sunstroke, Dr. Hamilton repeatedly confined Mr. Brown in a heated pit until he lost consciousness. Dr. Hamilton was also curious about the thickness of Black skin, and induced blisters to Mr. Brown's hands, legs, and feet.[226]

The belief that Black people are less sensitive to pain, established by white physicians working with slaves, persists in modern medical practice and decision-making.[227] Black patients experience disparities in pain management across medical specialties, from treatment of long bone fractures in the emergency department to perinatal care.[228,229] According to one study published in the American Journal of Emergency Medicine in 2019, Black patients were still 34 percent less likely to receive opioids for acute pain than were white patients, and Hispanic patients were 13 percent less likely to receive opioids for acute pain.[230] While physicians and physician assistants aim to improve the health and quality of life in our communities, we cannot claim that we treat our patients without bias. Implicit bias, which has unconscious influence on our decision-making, affects every member of society. These biases are influenced by the communities in which we grow up and by our medical training.[104]

Examples of abuse at the hands of clinicians and researchers did not end with the abolition of slavery. A U.S. Public Health Service Syphilis Study was performed at the historically Black Tuskegee University between 1932 and 1972. Six hundred Black men were entered into a study without their informed consent and were told they were being treated for "bad blood." The original project was to last six months but continued for 40 years, ending only after the study was revealed by the Associated Press and public outcry demanded an investigation. The participants did not receive proper treatment for the disease, even when penicillin became the drug of choice in 1947 and was widely available, in order to observe the natural progression of syphilis.[231]

There are other examples of medical exploitation of human subjects in pursuing research, scientific discovery, medical device development, and commercial enterprise. One such example is found in the history of HeLa cells, the story of how Dr. George Gey of Johns Hopkins University developed a durable and prolific line of cells for research. He used Henrietta Lacks' tissue without her knowledge or consent, and without informing her family. Prior to her death in 1951, she provided the first immortal human cells ever grown in culture; these cells continue to be used in research but are best known for providing an essential tool in the development of the polio vaccine. These cells have been instrumental in the development of a multi-billion-dollar medical industrial complex.[232]

These examples demonstrate a few of the many reasons why Black individuals and communities may mistrust the U.S. medical system. The fears of being used as non-consensual research subjects has caused mistrust in public health programs and medical treatments, including needle exchange programs, sickle cell screening programs, birth control programs, and protease inhibitors for HIV.[233,234]

Beyond research exploitation of the vulnerable there are also examples of societal devaluation of life with quiet collaboration by the medical community. In an attempt to decrease or eliminate "undesirable" features in U.S. society, sterilization laws were enacted in 30 states, culminating in 60,000 forced sterilizations that targeted immigrants, minorities, and impoverished people.[235] Between 1970 and 1976, 25 percent of Native American women were sterilized, often without full informed consent, and Black and Latina women were also targets of coercive sterilization.[236] In 2013, the Center for Investigative Reporting found that female inmates in California were sterilized without consent, and in 2017 a Tennessee judge issued an order offering prison inmates a sentence reduction if they agreed to permanent birth control.[237] Allegations of sterilization of vulnerable populations without full informed consent continued in 2020.[238]

A diverse healthcare workforce is critical to achieving health equity.[239] The persistent underrepresentation of Black medical professionals is multifaceted but can be attributed, at least in part, to historical lack of access to training and exclusion from professional organizations. There were a limited number of Historically Black Colleges and Universities with medical schools at the turn of the last century when the white medical schools would not admit Black people. The majority of these schools closed down within a decade of the 1910 Flexner Report due to pressures related to more stringent credentialing requirements and inadequate funding, reducing the number of Black physicians educated and available to the Black community.[240]

Like the medical schools, the AMA did not admit Black physicians until 1965, after legislation required it to do so. The NMA was formed in 1868 by an integrated group of physicians at Howard University, a historically Black university. The NMA requested admission to the AMA at the time but was voted down 114 to 82. The AMA denied the vote had been about race for more than 100 years, but ultimately a letter of apology was written to the NMA and was carried over and read to the NMA in 2008.[82] We do not have documentation as to whether the OMA followed the bylaws and guidance of the AMA in regard to race.

Oregon healthcare leaders have recognized the need for improved diversity in the workforce. Efforts to recruit diverse students and trainees to the state already exist in training programs; notably, Oregon Health Sciences University has made effort in this area for over 25 years through medical school and residency admissions processes with some successes. In 2017, the Oregon Legislature enacted House Bill 3261, directing the Oregon Health Policy Board to conduct regular assessments of the health care workforce needs of the state. Increasing the

diversity and cultural competence of the health care workforce in the state of Oregon has been recognized as a tool to address the growing racial, gender, and ethnic diversity of the state.[241] Nonetheless, our health care workforce continues to lack needed diversity in many areas and ongoing investment in strategies for change is needed.[242]

Disparities in Health Outcomes

After a history of abuse, inequity, and a lack of representation in medicine, Black people have many reasons to doubt they will receive equal care.[243] This ongoing mistrust of the U.S. healthcare system contributes to lower care utilization by Black Americans.[244] Black Americans receive less preventative care and chronic care and have higher rates of chronic disease-related hospitalizations.[245] They are more likely to die when they receive treatment, they have lower survival rates from treatable diseases, they die more frequently during childbirth, they have increased risk of dying prematurely in childhood when compared with white Americans, and collectively Black Americans have a lower life expectancy.[246,247,248,249] Even after correcting for socio-economic status and insurance, these disparities in health outcomes still exist.[250] These outcome differences exist as far back as race-based data have been collected.[251]

Racial disparities in health outcomes are truly disturbing. Black children are 50 percent more likely to be born with low birth weight. Infant mortality is 2.3 times higher for the children of Black mothers than for those of white mothers. Black infants are 3.8 times more likely to die from complications related to low birth weight and two times more likely to die from sudden infant death.[252] Additionally, Black, American Indian, and Alaskan Native women are two to three times more likely to die from pregnancy-related causes than are white women. For women older than 30, this ratio becomes four to five times as high.[253]

The incidence of hypertension in Black people is 42 percent, while that in white people is 25 percent. The diabetes rate in Black people is 13 percent, compared to white people at six percent. Black death rates from diabetes (73 per 100,000) are higher than for whites (29 per 100,000). Black death rates for stroke (85 per 100,000) compare unfavorably to those of whites (56 per 100,000). Black people are significantly more likely to die from heart disease, stroke, diabetes, or cancer compared to whites.[129]

It is well documented that these inequitable health outcomes are not limited to Black Americans. According to the 2018 National Healthcare Quality and Disparities Report, racial and ethnic disparities in care were getting smaller from 2000 through 2016-2017, but persist, especially for poor and uninsured populations. Blacks, American Indians and Alaska Natives (AI/ANs), and Native Hawaiians/Pacific Islanders (NHPIs) received worse care than whites for about 40 percent of quality measures and disparities were improving for only 4 measures for Blacks, 2 measures for AI/ANs, and 1 measure for NHPIs.[254] Black Americans and other communities of color experience a lower life expectancy than white Americans.[247]

Despite the best intentions and efforts of clinicians who try to provide care to each patient equally, differences in how care is made available and delivered by medical systems (independent of social determinants of health) may contribute to inequitable outcomes. Commonly used race-based medical research contributes to sustaining race-based medicine and may play a role in worse outcomes for Black patients. One example is the race-adjusted laboratory value for eGFR, a marker of kidney function. Originally attributed to differences in muscle mass, this race-adjusted value may overestimate kidney function, leading to later initiation of advanced treatments, delays in listing for renal transplant, and possibly worsening outcomes from kidney failure in patients categorized as “Black.”[255] In another example, the

American Heart Association guidelines assign additional points for heart failure risk for anyone who is “non-Black” resulting in all Black patients being categorized as lower risk and potentially delaying diagnosis and treatment.[255,256,257]

Further examples of differences in care abound. A 2007 study reported that pulse oximeters, routinely used in medicine and surgery, are less accurate at low oxygen saturations for patients with dark skin.[258] This inaccuracy may have a significant and adverse impact on medical decision making. Another example is BiDil, the heart failure drug marketed for Black people whose clinical testing included self-reporting race without any genetic evidence of differences in CHF between Black patients and other races.[259]

These examples of race-based medicine and research highlight the need for clinicians and scientists to replace race with factors measurable by clinicians and develop biologically based approaches to care and research unless the sociopolitical forces are directly pertinent.[256,257,260,261] Additional effort is needed to alter how race is portrayed during medical education and training so that embedded racism is not perpetuated inadvertently by being passed on to the next generation of physicians and PAs.[262] Finally, medical training and practice must account for the impact of historical and personal traumas on the care experience and clinicians must learn to provide trauma-informed care.[263]

As has been described above, racial differences in American healthcare begin even before patients enter clinical care. In addition to the ways race affects social determinants of health and the delivery of care, unlike most other industrialized nations American access to health care depends critically upon a patient’s employment, age, education, and ability to pay. As a consequence, Black Americans and other communities of color are more likely to be uninsured,[264] to have unaffordable deductibles and copays if they are insured,[265] to be less likely to seek care when needed, and to be more likely to have incurred complications before they receive care.[266,267] Obstacles to health insurance compound pre-existing problems endured by Black Americans through inequitable access to education, police protection, employment, and housing, as well as the complicated relationship Black Americans have with the medical system because of historical betrayals of trust.[250]

Social determinants of health enumerated in earlier sections of this document and lower rates of access and utilization of healthcare services are contributors to the disproportionate impact of epidemics on the health of Black people. Events of 2020-2021 have underscored these effects. Significant and pervasive differences in outcomes from COVID-19 have been documented for Black Americans.[248] In one study of a large cohort of patients in Louisiana, 70.6 percent of those who died of SARS-CoV2 were Black while they comprised only 31 percent of the local hospital system population.[268] In another example, this one of adults aged 45 to 54, Black and Hispanic COVID-19 death rates were at least six times higher than those of white people nationally.[269]

A 2021 mid-pandemic systematic review of racial and ethnic disparities in COVID-19 related infections, hospitalizations, and deaths has demonstrated that Black and Hispanic populations experience disproportionately higher rates of infection and mortality but similar rates of case fatality, more likely due to exposure-related factors. These factors, in turn, represent one health risk and demonstrate the impact of the environments in which these individuals live and work.[270] 58 percent of our population depends upon employment and ability to pay to access health care,[271] thereby exacerbating adverse public health consequences in communities of color that experience simultaneous loss of employment, income, health insurance, and good health.[248]

Adverse history, unsatisfactory experiences, and limited means creating limited access define the Black experience with health care. **These have resulted in longstanding health outcomes disparities, which COVID has further emphasized over the last year. Correcting health outcomes for a community whose circumstances define their risk can only be successful by altering the sociopolitical factors that limit opportunities, environment, and access to care.** This is an ongoing public health crisis.

A Call to Action

There are clear racial disparities in health care delivery and outcomes. Racism in this country has an intergenerational impact with varying manifestations. Systems influenced by racism affect safety within Black communities and interactions with law enforcement. They reduce access to educational opportunities, acquisition of wealth and secure housing, and result in bias in society affecting our media and systems of justice. Current policies of law enforcement and justice place lives and health at risk. Other ethnic and racial groups targeted by systemic racism have a similar experience.

White patients fare better than do patients of color. Decades of reform attempts have not changed this at the state or national level. An institution that generates worse outcomes for Black people and other people of color must be considered a “racist” institution. Based on our nation’s history of race in medicine and persistent racial disparities in health access and outcomes, the American healthcare system is racist.

Until recently, physicians, PAs, and other healthcare allies have not taken a stand in opposition to racist public policies even when the downstream effects on health and access to health care are seen. Historically, the healthcare system in this country has played a role in perpetuating and participating in systems of racism even if individual clinicians have tried to resist. Health outcomes are predictably worse for people affected by racism in this country. The scope of the problem is large; the social and economic determinants of health cannot be separated from our country’s racist history. Thus, there are many areas outside healthcare requiring change for health outcomes to improve.

The responsibility for change is both individual and institutional. Examples of institutional changes were the 13th, 14th, and 15th Amendments. Though these provided a framework, the full fruition of these amendments remains to be realized, as described above. If hearts and minds do not change in parallel with institutional change aimed at eliminating disparities, or worse, if there is backlash, racist outcomes will persist. Individuals, including members of the OMA, must acknowledge that passive tolerance of racist outcomes or active resistance to institutional change will perpetuate disparities.

Our healthcare institutions, with sustained and unrelenting race-based outcomes, must acknowledge the role of structural racism. Structural racism in healthcare is not simply the sum of individual actions- these are not the main drivers of racially differentiated outcomes- but reflects racism incorporated into our professional institutions. Racism may not always be intentional, but it remains actively at work. Centuries of white domination produced a healthcare system that reflects white interests. Close scrutiny reveals that racist policies are embedded in our profession. Dismantling racism begins with individual self-reflection, yet primarily requires large-scale institutional change in policies including those affecting access to and delivery of health care. This may require including new voices when creating those health care policies. The OMA must provide leadership for institutional changes to be embraced. These changes must reduce or eliminate our racially differentiated outcomes to be considered successful.

As representatives of Oregon's medical community, we commit ourselves to reversing the manifold health consequences of our country's history of racism. The OMA cannot assume the associated guilt of centuries of racist oppression in society and medicine, but we must assume responsibility for change. We know that social inequities persist in American society. Therefore, the OMA will advocate for policies that improve the health of our communities and provide health care access to all races in order to mitigate and reverse these preexisting social inequities.

We as clinicians need to learn to see not only race, but the person beneath the surface. We need to work against the tendency to oversimplify people using stereotypes, either consciously or subconsciously. Deliberate suppression of racial awareness is not truly possible, nor is it useful. A racial lens exists in all of us, and it is best to be conscious of it. Race awareness is the first step toward generating equitable outcomes through our practice, profession, and institutions.

The OMA starts by publicly acknowledging the racially differentiated outcomes in health care and the impact of racism on health in our state; by increasing the awareness within our professional community that our own practices may inadvertently contribute to inequitable outcomes; by focusing on structures and policies within our institutions that determine who gets care, who pays for care, who delivers care, how healthcare resources are allocated, and who allocates those resources; and by accepting that significant change in outcomes requires significant change in our healthcare system, our government, our laws, and our practice.

We have the responsibility to focus on these problems, to contribute to finding solutions, and to help heal the harms done by racism. The OMA must advocate for the interests not just of our profession and our patients, but of our society.

Definitions/Terminology

Ally: "An ally is any person that actively promotes and aspires to advance the culture of inclusion through intentional, positive and conscious efforts that benefit people as a whole. Everyone has the ability to be an ally as privilege is intersectional -- white women can be actionable allies to people of color, men can be allies to women, cis people can be allies to members of the LGBTQ+ community, able-bodied people can be allies to those with different ability, economically privileged people can be allies to those who are not and so on."[118]

Allyship: "A lifelong process of building relationships based on trust, consistency, and accountability with marginalized individuals and/or groups of people. Not self-defined -- work and efforts must be recognized by those you are seeking to ally with. An opportunity to grow and learn about ourselves, whilst building confidence in others."[272]

Antiracism: "Active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes so that power is redistributed and shared equitably."[273]

Antiracist: "One who is supporting an antiracist policy through their actions or expressing an antiracist idea."[274]

Black vs. African American: We use the term "Black" to be inclusive of all those who experience current systems of racism against those with dark skin as this experience is shared

by both those who are descended from enslaved Africans brought to North America and others who have more recently immigrated from African, Caribbean, and other countries. The term African American may be more appropriately applied to those who have been in this country for generations and who can often trace their roots to the enslaved people who helped build this country.[275]

Color blindness: “Civil rights leaders are quick to assure the public that when we reach a colorblind nirvana, race consciousness will no longer be necessary or appropriate. Far from being a worthy goal, however, color blindness has proved catastrophic for Black people…. Our blindness … prevents us from seeing the racial and structural divisions that persist in society: the segregated, unequal schools, the segregated, jobless ghettos, and the segregated public discourse -- a public conversation that excludes the current pariah caste…. We have become blind, not so much to race, but to the existence of racial caste in America.”[118] While intention when aspiring for color blindness may have been good, the effect has been to be blinded to the impact of racist systems and implicit bias on the lives of people of color.

Implicit bias: “The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual’s awareness or intentional control.”[109]

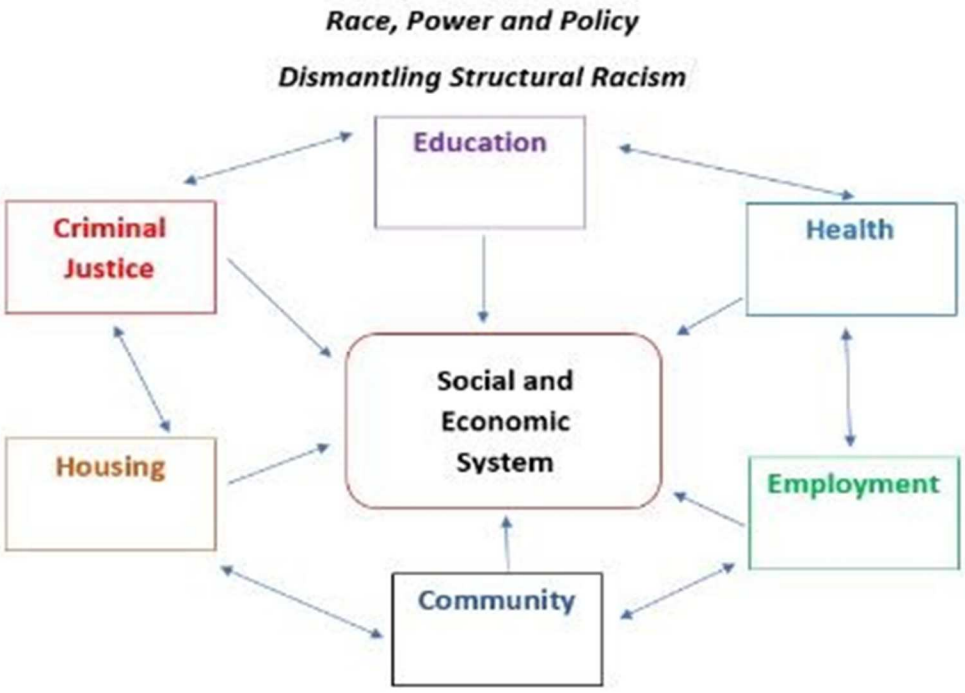
Microaggressions: "The everyday verbal, nonverbal, and environmental slights, snubs or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.”[276]

Public health issue: “For a health problem or condition to be considered a public health issue, four criteria must be met: 1) the health condition must place a large burden on society, a burden that is getting larger despite existing control efforts; 2) the burden must be distributed unfairly (i.e., certain segments of the population are unequally affected); 3) there must be evidence that *upstream* preventive strategies could substantially reduce the burden of the condition; and 4) such preventive strategies are not yet in place.”[277]

Racism: “A system of dominance, power and privilege based on racial group designations… where members of the dominant group create or accept their societal privilege by maintaining structures, ideology, values, and behavior that have the intent or effect of leaving non-dominant group members relatively excluded from power, esteem, status and or equal access to societal resources.” [278]

Racist: “One who is supporting a racist policy through their actions or inaction or expressing a racist idea.”[274]

Social determinants of health: “Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.”[279]



Source: Moreland-Capuia A. *Training for Change: Transforming Systems to be Trauma-Informed, Culturally Responsive, and Neuroscientifically Focused.* Springer; 2020.

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APPENDIX O

APPENDIX O: CLIMATE AND HEALTH

The Lancet Commission on Climate Change and Health released its second report in 2015 finding that, "...tackling climate change could be the greatest global health opportunity of the 21st century" and "[t]he effects of climate change are being felt today, and future projections represent an unacceptably high and potentially catastrophic risk to human health;" Health professionals have an obligation to advocate for efforts to improve the health of our patients. Action on climate change is generally considered to be either mitigation (minimizing effects by decreasing changes) or adaptation (minimizing damage due to inevitable changes), and can be attempted as an individual, community, or legislatively.[2] The report has since been updated regularly, most recently in 2020.[3]

Health care professionals, including physicians and physician assistants have an obligation to advocate for efforts to improve the health of patients. Early in 2021, the OMA's Policy Committee assembled a Climate Change Workgroup to develop policy on the issue of Climate Change for consideration at an upcoming Board of Trustees meeting. The workgroup would center its focus to consider the likely effects of climate change in Oregon, and nationally, and identify impactful strategies for further safeguarding the heath of Oregonians as it pertains to illness, death, and injuries, including but not limited to, mitigation and adaptation strategies that could be enacted at the personal, community and legislative level.

The workgroup considered existing policy from the American Medical Association and based its first recommendation on AMA's Policy on Global Climate Change and Human Health, adapting it to physician assistants and the health care team.[4] The AMA has been involved in Climate issues and has reaffirmed and updated this policy in recent years. In addition to the AMA's policy, the workgroup also examined other policies, statements, and resources from national and state medical associations.

One of those resources, The U.S. Call to Action on Climate, Health and Equity acknowledges climate change as the greatest public health challenge of the 21st century, takes action to reduce climate change to dramatically improve health and assures that equity is central to climate action. Medical Associations such as the AMA, the American College of Physicians, the American Academy of Family Physicians, and many other stakeholders including public health organizations called on government, business, and civil society leaders, elected officials, and candidates for office to recognize climate change as a health emergency and to work across government agencies and with communities and businesses to prioritize action on their Climate, Health and Equity Policy Action Agenda.[5]

With the recommendations, the OMA would have policy to guide its education, legislative activities, and operational decisions. These recommendations will further the OMA's goals of a healthier community and world.

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Resources from health care organizations
Though the list below is not exhaustive, it includes some of the resources the workgroup reviewed in developing its recommendations.

American Medical Association Policy
The Lancet Report 2020
American College of Physicians Climate Change Toolkit
Climate Change and Health: A Position Paper of the American College of Physicians
The U.S. Call to Action and the Climate, Health, and Equity Policy Action Agenda
Confronting Climate Change: NW Permanente in the Environment of the Future
American Lung Association – Health Professionals for Clean Air and Climate Action
Practice Greenhealth
The Medical Society Consortium on Climate & Health: Take Action
The Medical Society Consortium on Climate & Health: Candidate Questions
Intergovernmental Panel on Climate Change: AR6 Climate Change 2021

Policy Committee Workgroup on Climate and Health
Colin Cave, MD, Otolaryngology, Portland
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Stewart Decker, MD, Family Practice, Klamath Falls, Chair
Erika Moseson, MD, MA, Critical Care Medicine, Portland
Marianne Parshley, MD, Internal Medicine, Portland

APPENDIX P

APPENDIX P: POLYPHARMACY AND DEPRESCRIBING

The Policy Committee was tasked with assembling a small workgroup to tackle polypharmacy and deprescribing, based on a resolution from two members in 2019 that called for the Policy Committee to make recommendations on a process to identify and mobilize best practices around deprescribing.

Polypharmacy, defined as regular use of at least five medications, is common in older adults and younger at-risk populations and increases the risk of adverse medical outcomes.[1] According to a study on the trends in prescription drug use among adults from 1999-2012, 39% of patients over 65 take 5 or more prescription medications..."[2] The number of medications is the strongest predictor of potentially inappropriate medication use.[3]

According to a report by the Centers for Disease Control and Prevention from 2019, 83% of U.S. adults in their 60s and 70s had used at least one prescription drug in the previous 30 days and about one-third used five or more prescription drugs. The most commonly used drugs were cholesterol, high blood pressure, and diabetes medications.

Inappropriate polypharmacy - the use of excessive or unnecessary medications - increases the risk of adverse drug effects, including falls and cognitive impairment, harmful drug interactions, and drug-disease interactions, in which a medication prescribed to treat one condition worsens another or causes a new one. Patients may be prescribed medicines that are unlikely to help, potentially harmful, or misaligned with the person's health goals. Polypharmacy also creates a tremendous burden for patients and their families, who need to understand the purpose of the many prescriptions written by multiple providers, get refills, take each medication at the correct time of day, and recognize side effects.[4]

The members of the workgroup, worked with other clinical advisors from the Oregon Chapter American College of Physicians who provided input. Because of the complexity of the polypharmacy issue, there is no one single protocol, algorithm, or guideline for deprescribing, that can be applied to all patients and each physician and physician assistant must determine with their own clinical approach how to address this problem.

The Oregon ACP and the Oregon Geriatrics Society recently developed continuing medical education; a 4-part series to help clinicians design a plan for deprescribing. That series is titled "Tackling Prescription Overload." But more is needed for awareness and resources.

The recommendations set the stage for collaboration between the Oregon Medical Association and other stakeholder organizations who are already involved in polypharmacy and to introduce, educate and advocate effectively for patients through this collaboration.

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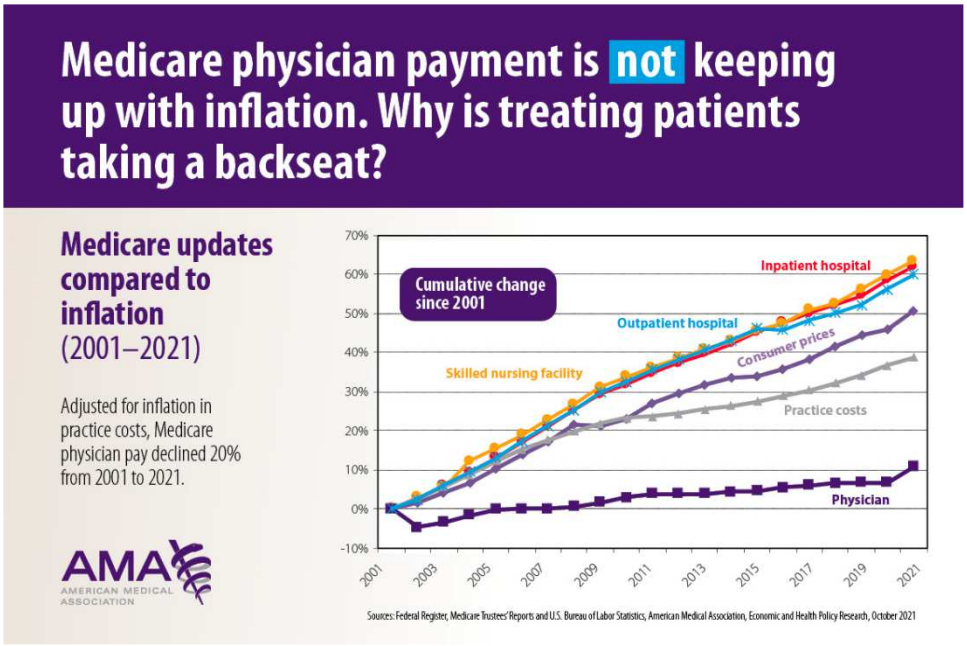
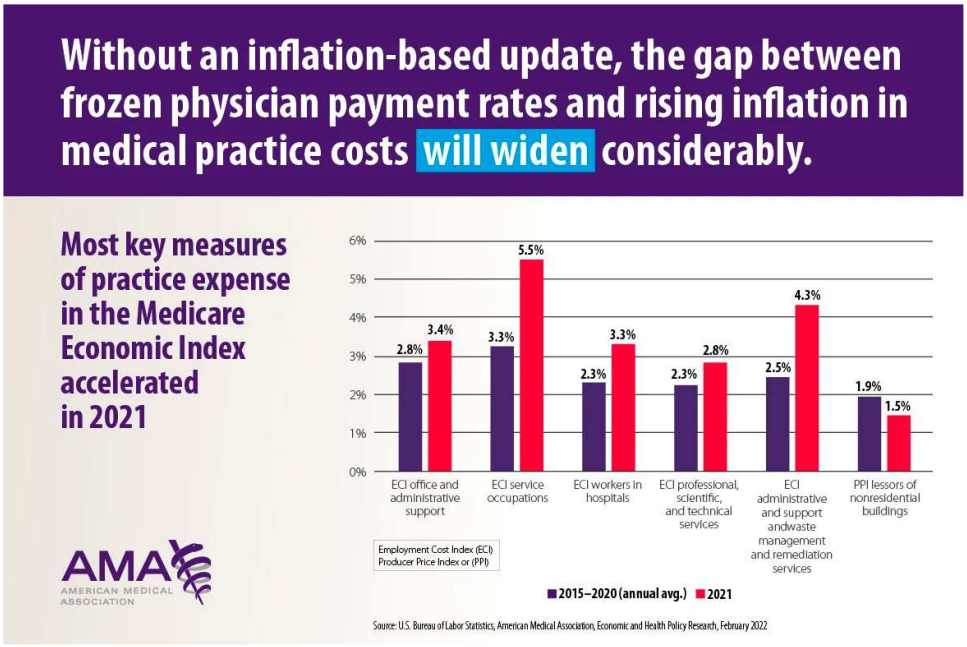
APPENDIX Q

APPENDIX Q: RATIONAL MEDICARE PAYMENT SYSTEM

In June 2022, the American Medical Association developed a set of principles in collaboration with Federation organizations including the Oregon Medical Association. The set of principles[1] provides a framework for payment reform as an early step in the AMA's effort to develop consensus across medicine on policy recommendations that would reshape the payment system to work better for patients and physicians and their medical teams and put an end to the annual advocacy exercise of stopping impending payment cuts.[2,3]

According to the AMA, when adjusted for inflation in practice costs, Medicare physician payment fell 20% from 2001 to 2021, and without an inflation-based update, the gap between frozen physician payment rates and rising inflation in medical practice costs will widen. This issue with the Medicare payment system will in turn lead to problems with patient access.





The OMA will continue to work with AMA as it further develops concrete proposals to meet the goals set forth in the principles.

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1 AMA Principles Characteristics of a Rational Medicare Payment System with signatories
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APPENDIX R

APPENDIX R: GENDER-BASED VIOLENCE AND DISCRIMINATION IN HIGHER EDUCATION

Sexual violence involving physical contact and sexual harassment remain common problems within the U.S., with 1 in 3 women having experienced sexual violence involving physical contact according to the CDC;[2] and up to 85%[3] of employed women in the U.S. having experienced sexual harassment at work, according to the U.S. Equal Employment Opportunity Commission.[4]

Colleges and universities remain some of the locations with the highest prevalence of sexual assault, with 26.3% of all undergraduate senior women included in the National Institute of

[2] CDC, "Preventing Sexual Violence," Feb. 5, 2021, https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html

[3] The original range of 25-85% reported in these surveys was widely divergent. The investigators found that when they did not define sexual harassment in the survey, only 25% of women reported sexual harassment in the workplace. When they defined specific acts that constitute sexual harassment, however, 75-85% of women reported sexual harassment in the workplace.

[4] U.S. Equal Employment Opportunity Commission, "Select Task Force on the Study of Harassment in the Workplace," June 2016, https://www.eeoc.gov/select-task-force-study-harassment-workplace#_Toc453686298

Justice Campus Sexual Assault Study reporting having experienced a completed or attempted sexual assault[5] and 9.7% of female graduate and professional students reporting having experienced completed or attempted sexual assault within their program.[6]

Professional students in the health sciences fall into this demographic and women in medicine are at increased risk for sexual harassment when compared to women in other STEM fields. The National Academies of Science, Engineering, and Medicine (NASEM) finds that "women students in academic medicine experience more frequent sexual harassment perpetrated by faculty and staff than women students in science and engineering."[7] A review of the prevalence of sexual harassment in medical school found that 51.1% of medical students had experienced some form of sexual harassment from either a member of faculty/staff or a student.[8]

OMA has recognized this problem and resolved to promote NASEM guidelines to diminish workplace harassment and violence[9] and to support "institutional, local, state, and federal legislation that upholds and strengthens the rights and privacy of survivors of sexual harassment and violence and is survivor centered, including but not limited to changes made to Titles VII or IX."[10]

However, OMA does not yet have specific language addressing institutional self-interest, which may inhibit effective prevention of sexual harassment and gender-based violence. NASEM identifies the risks of this self-interest, writing, "Judicial interpretation of Title IX and Title VII has incentivized organizations to create policies, procedures, and training on sexual harassment that focus on symbolic compliance with current law and avoiding liability, and not preventing sexual harassment."[11] A pattern of symbolic compliance without intentional prevention or survivor support policies may create a culture in many institutions where sexual harassment and gender-based violence occurs unchecked, and many are afraid to report.[12] Underreporting of sexual harassment and sexual violence remains a salient issue,[13] likely due in part to the fact that 70

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[5] Krebs, et. al., "The Campus Sexual Assault Study," National Institute of Justice (NIJ) Grant No. 2004-WG-BX-0010, https://www.ojp.gov/pdffiles1/nij/grants/221153.pdf

[6] Krebs, et. al., "The Campus Sexual Assault Study," National Institute of Justice (NIJ) Grant No. 2004-WG-BX-0010, https://www.ojp.gov/pdffiles1/nij/grants/221153.pdf

[7] Johnson, Widnall, Benya, Ed. " Sexual Harassment of Women: Climate, Culture, and Consequences in
Academic Sciences, Engineering, and Medicine," *National Academies of Science, Engineering, and Medicine,* 2018, https://doi.org/10.17226/24994.

[8] McClain et. al., "Sexual Harassment Among Medical Students: Prevalence, Prediction, and Correlated Outcomes," *Workplace Health and Safety,* Dec. 2020, doi: 10.1177/2165079920969402.

[9] Oregon Medical Association, "Where we stand."

[10] Oregon Medical Association, "Where we stand."

[11] Johnson, Widnall, Benya, Ed. " Sexual Harassment of Women: Climate, Culture, and Consequences in
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[13] Rachel E. Morgan, Ph.D., and Jennifer L. Truman, Ph.D., "Criminal Victimization, 2019," *U.S. Department of Justice,* September 2020, pg 8, https://www.bjs.gov/content/pub/pdf/cv19.pdf.

percent of survivors who reported to their schools stated they experienced adverse effects on their safety and privacy, according to a study conducted by Know Your IX.[14]

Recognizing the need to improve institutional cultures of gender equity across institutions of higher education within Oregon, this workgroup sought to craft policy which would both promote prevention of gender-based violence and discrimination and would improve support for survivors. In crafting these recommendations, the committee examined work done by the Attorney General's Sexual Assault Taskforce in Oregon, model prevention and reporting programs such as those in place at the University of Oregon[15], NASEM policy, and the NASEM action collaborative on the prevention of sexual harassment in higher education.

After thorough study of the available resources, this workgroup drafted recommendations which will provide OMA with policy that both promotes the prevention of sexual harassment and gender-based violence and improves support for survivors at institutions of higher education in Oregon. This policy will further OMA's goal of a healthier, safer Oregon by improving the health and safety of an at-risk group across all institutions of higher education within Oregon as well as within Oregon's medical training programs.

JEDI Committee Gender-Based Violence and Discrimination in Higher Education Workgroup

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Appendix A:

DEFINITIONS:

Sexual harassment is a form of discrimination that includes gender harassment (verbal and nonverbal behaviors that convey hostility to, objectification of, exclusion of, or second-class status about members of one gender), unwanted sexual attention (verbally or physically unwelcome sexual advances, which can include assault), and sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity) (NASEM, 2018). Importantly, pervasive sexual harassment that creates a hostile work environment can constitute illegal discrimination (MacKinnon, 1979; USEEOC, 1980).[16]

Gender-based violence refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms.[17]

[14] Sarah Nesbitt, Sage Carson, Sonia Ghura, and Josephine O'Brien, "The Cost of Reporting: Perpetrator Retaliation, Institutional Betrayal, and Student Survivor Pushout," *Know Your IX*, 2013.
[15] University of Oregon, Help for Victims and Survivors, https://safe.uoregon.edu/.
[16] National Academies, Guidance for Measuring Sexual Harassment Prevalence Using Campus Climate Surveys, https://www.nationalacademies.org/news/2021/09/guidance-for-measuring-sexual-harassment-prevalence-using-campus-climate-surveys.
[17] United Nations: Women, https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence.

Culture survey refers to a survey that elicits information about the collectively held beliefs, assumptions, and values held by organizational members regarding sexual harassment and gender-based violence. Culture guides and sets the tone for the climate that members of an organization experience.[18]

Climate survey refers to a survey that elicits information about the shared perceptions within an organization regarding incidence of sexual harassment and gender-based violence, organizational policy surrounding sexual harassment and gender-based violence, as well as the reporting process. Climate reflects and supports the culture of the organization.[19]

The iceberg refers to a metaphor for gender-based violence and sexual harassment in the public consciousness. Namely, this metaphor points out how only the most egregious incidences of gender-based violence (rape, professional rewards for sexual favors, etc.) attract public attention, but more subtle aggressions which constitute the majority of sexual harassment within institutions go unnoticed.[20] (For more information, please see **Appendix B**).

Mandatory reporters are required by state law to report specific instances of abuse as defined by the state of Oregon to state authorities.

Designated reporters are required by their institutions to report any information they receive regarding sexual harassment or sexual violence to the Title IX Coordinator.[21]

Assisting employees are not required by their institutions to share disclosures of prohibited discrimination unless the information conveyed suggests a threat to the health or safety of any person. They are required to provide the person making the disclosure with information about reporting options and support resources.[22]

Confidential Employees will maintain confidentiality while offering information, resources, and reporting options.[23]

Appendix B

[18] National Academies, Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine, https://nap.nationalacademies.org/read/24994/chapter/8.
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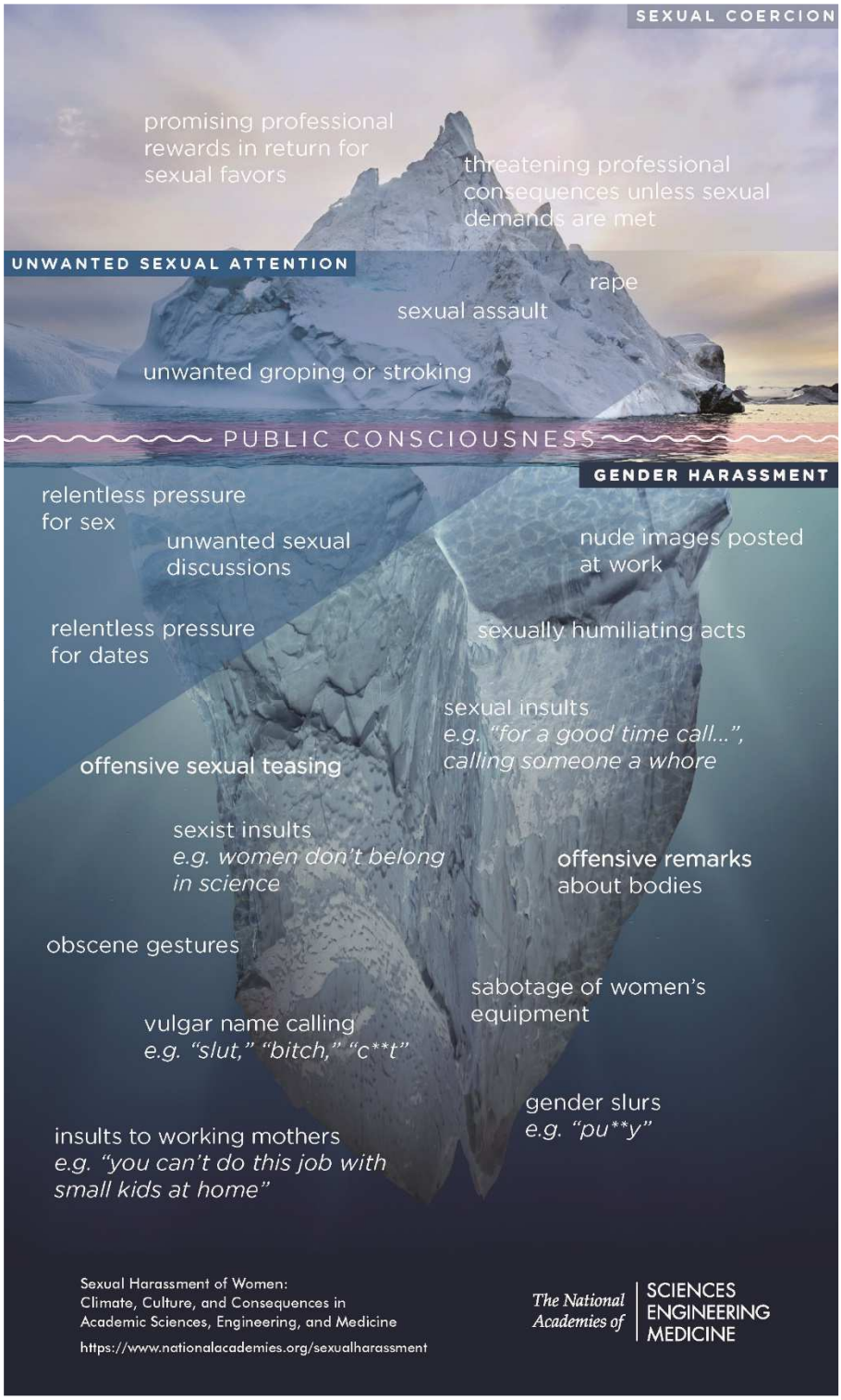

APPENDIX S

APPENDIX S: CONTROL OF UTILIZATION AND COSTS

1. That the OMA adopt the following AMA Prior Authorization and Utilization Management Reform Principles:

a. Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.
b. Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.
c. Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.
d. Utilization review entities should offer a minimum of a 60-day grace period for any step-therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.
e. A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
f. A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.
g. No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.
h. Utilization review entities should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request.
i. Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.
j. Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publicly available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:
    i. Health care provider type/specialty;
    ii. Medication, diagnostic test or procedure;
    iii. Indication;
    iv. Total annual prior authorization requests, approvals and denials;
    v. Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submission; and
    vi. Denials overturned upon appeal.

    These data should inform efforts to refine and improve utilization management programs.

k. Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.
l. A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.
m. Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
n. In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.
o. If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
p. Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination.
q. Prior authorization should never be required for emergency care.
r. Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens.
s. Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.
t. Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.
u. A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.

2. That the OMA continue actively working on Prior Authorization reforms through workgroups, task forces, and the legislative process.

COMMENTS

The complexity of patient benefits, coupled with differing authorization processes for each insurer, makes it difficult for both the patient and clinical staff to secure appropriate authorizations in an efficient amount of time. Practices often contract with many insurers including local health plans, national insurers, Medicare and Medicaid as well as Tricare and workers' compensation. The inefficiencies of differing forms and requirements have meant increased costs that do not improve patient care and in some cases, could be detrimental to the patient.

In the 2011 Oregon Legislative Session, OMA worked to pass SB 94, which set uniform standards to simplify administrative processes between providers and payers. These processes included determining if someone had insurance, submitting a claim to be paid, prior authorizations, and provider credentialing.

In the following 2013 session, OMA made further strides on the issue by passing SB 382, which developed a standardized authorization form for prescriptions to be accessible and utilized within a provider's system. However, the bill was amended to allow insurers to request additional information to what will be included on the two-page form which led to a request for information on the original insurer prior authorization form.

The OMA participated on the Oregon Health Leadership Council's Administrative Simplification Prior Authorization Workgroup from 2012-13. This workgroup developed best practice recommendations for Prior Authorization including standard definitions; recommended timeframes for responding to prior authorization requests; a one-stop shopping tool through a secure portal providing basic information for each payer and links to the PA section of payer website; and a template for a common form to standardize the information routinely requested from providers. The OMA continues to participate on the OHLC's Administrative Simplification initiatives, which identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals to streamline the business side of health care and provide cost-savings to the entire system.

OMA is currently developing a coalition of interested stakeholders to put together legislative concepts for future sessions.

APPENDIX T

APPENDIX T: PROTECTIONS FOR LGBTQ+ HEALTH PROFESSIONALS

Despite the importance of LGBTQ+ representation, LGBTQ+ people are highly underrepresented in medicine and science. LGBTQ+ people are estimated to comprise 10–15% of the US population (GLAAD, 2017), with increasing representation in younger generations, but the American Medical Association estimates that only about 4% of US physicians identify as LGBTQ+ (Tanner, 2020).

LGBTQ+ health professional students are more likely to experience burnout, which is associated with their higher likelihood of mistreatment (Samuels et al., 2021). Studies have shown greater discrimination and harassment of LGBTQ+ people in medical school (Hill et al., 2020) and residency training (Pololi et al., 2020). Mansh and colleagues (2015) found that 29.5% of LGBTQ+ trainees surveyed concealed their identity in medical school, with 43.5% citing fear of bias and harassment as a reason for concealing their sexual identity (Mansh et al.,

2015). Transgender and non-binary health professional students reported self-censorship of their speech or mannerisms to avoid disclosure of their identity, hearing derogatory comments, and witnessing discriminatory care (Dimant et al., 2019).

A study of LGBTQ+ physicians found that they experienced harassment and social ostracism and witnessed discriminatory treatment of LGBTQ+ patients, patients' partners, and colleagues (Eliason et al., 2011). A recent study of health professional students and dual degree medical trainees found that a higher percentage of LGBTQ+ dual degree trainees (15.50%) identified sexual harassment as a past barrier to career advancement compared to their non-LGBTQ+ peers (8.27%) (Marr, Heffron, & Kwan, 2022). LGBTQ+ physicians commonly face discriminatory behavior from patients, with 42% of residents in a recent survey reporting witnessing discrimination within the past year (de Bourmont et al., 2020).

Status as an LGBTQ+ person in science, technology, engineering, mathematics (STEM) professional fields is an independent predictor of experiencing career limitations, harassment, professional devaluation, more frequent health difficulties, and greater likelihood of intending to leave STEM (Cech & Waidzunas, 2021). Heteronormative assumptions and environments often silence conversations about gender and sexuality in medicine and STEM workplaces, leading LGBTQ+ trainees and scientists to report feeling "invisible" (Bilimoria & Stewart, 2009; Cech & Waidzunas, 2011; Cook et al., 2020; Miller et al., 2020; Powell, Terry, & Chen, 2020).

Healthcare professionals providing gender-affirming and LGBTQ+-related care are increasingly facing threats, violence, and harassment (HRC, 2022). Additionally, many states are criminalizing the provision and receipt of gender-affirming and/or LGBTQ+-related healthcare (Park, Das, & Drolet, 2021; Kraschel et al., 2022; Turban, Kraschel, & Cohen, 2021).

Physicians, Physician Assistants, and other healthcare professionals deserve to be protected in their work environments. Protections for LGBTQ+ health professionals and health professionals providing gender-affirming and/or LGBTQ+-related healthcare is critical. In order to develop policies for the OMA, this workgroup reviewed and considered existing policies from the AMA and the GLMA: Health Professionals Advancing LGBTQ+ Equality. In addition to examining these policies, the workgroup also reviewed other policies, statements, studies, and resources from state and national medical associations and organizations advocating for LGBTQ+ health.

These recommendations will become Oregon Medical Association policy and allow the OMA to advocate, influence, and educate to advance and improve protections for LGBTQ+ health professionals and health professionals providing gender-affirming and/or LGBTQ+-related healthcare. These recommendations will further the OMA's goals of advocating for an equitable and accessible healthcare environment and supporting the community of physicians and physician assistants.

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[1]GLMA: Health Professionals Advancing LGBTQ+ Equality does not generally spell out the acronym “GLMA” as part of the name since adopting a more inclusive organizational name.

APPENDIX U

APPENDIX U: SUPPORT FOR GENDER-AFFIRMING AND LGBTQ+ HEALTHCARE

Lesbian, gay, bisexual, transgender, queer, and other sex, sexual, and/or gender minority (LGBTQ+) people experience significant health disparities compared to their cisgender and heterosexual peers. Cardiovascular disease, certain cancers, mental health disorders, substance use, and sexually transmitted infections occur in higher rates in the LGBTQ+ population (Barger et al., 2020; IOM, 2011; Gonzalez, Gallego, & Bockting, 2017; Kidd et al., 2020; Nagata, Ganson, & Austin, 2020; Price-Feeney, Green, & Dorison, 2020; Rath et al., 2013; Russell & Fish, 2016; Scannapieco, Painter, & Blau, 2018). LGBTQ+ people are more likely to experience poverty and have more physical and mental health conditions (Choi & Meyer, 2016).

Beyond health disparities, there are also differences in access to care, resources, and social support. Poverty, stigma, depression, homelessness, and social isolation are more common in the LGBTQ+ community (Valenti et al., 2020). Older LGBTQ+ adults may also feel the need to hide their identity in healthcare or long-term care settings and may not have legal relationships with their partners because of past discrimination or stigma. LGBTQ+ older adults are more likely to experience social isolation and loneliness, and to worry about having adequate support from family and friends (Fasullo et al., 2022; Freedman & Nicolle, 2020; Preston, 2022). They are also more likely to rely on long-term care facilities (Fasullo et al., 2022).

Over half of LGBTQ+ individuals have faced bias or discrimination as part of their interactions with the healthcare system (Hurd, 2015; Preston, 2022). Fear of discrimination, harassment, or poor treatment in healthcare settings, lead many LGBTQ+ people to delay seeking care (Casey et al., 2019; Grant et al., 2011; Macapagal, Bhatia, & Greene, 2016; Mizra & Rooney, 2018). Studies have shown that 18.4% of LGBTQ+ individuals and 30.8% of transgender individuals who have experienced discrimination or harassment in healthcare settings, avoid future care because of concerns about a repeat of their negative experiences (Jaffee, Shires, & Stroumsa, 2016; Mizra & Rooney, 2018).

Healthcare forms and policies are based on heteronormative assumptions. LGBTQ+ adults may find that their partners are not allowed to visit because of hospital policies or that the forms do not reflect their legal name and gender (Adams, 2022; Hurd, 2015). Additionally, LGBTQ+ individuals may want to involve “chosen family” and friends in their care, instead of legal or biological relatives (Hurd, 2015), which runs counter to the current medical ethics recommendations (Dickson et al., 2020; Wahlert & Fiester, 2012). Guidance about how to navigate the medical-legal system, so that partners and friends can play an active role in decision making, as necessary, is especially important for LGBTQ+ individuals.

Transgender, non-binary, and gender diverse individuals face significant and pervasive discrimination in employment, housing, and healthcare (Medina & Mahowald, 2023). They also experience significant physical health, mental health, and social disparities exacerbated by structural stigma and ongoing legal attacks (Medina & Mahowald, 2023; National Academies Press, 2020). Transgender, non-binary, and gender diverse individuals face high rates of violence, including fatal violence, and hate crimes (Human Rights Campaign Foundation, 2022).

Studies suggest that gender-affirming care supports the well-being of transgender and gender-diverse youth, reduces suicidality, and improves psychological functioning (De Vries et al., 2014; Tordoff et al., 2022). The recent legislation and bans on gender-affirming care have been shown to increase symptoms of depression, anxiety, suicidal ideation, and gender dysphoria; and decrease youths’ sense of safety (Abreu et al., 2022). Youth also reported increased stigma and a lack of access to medical care as a result of the gender-affirming care bans (Abreu et al., 2022). Parents of transgender and gender-diverse youth want legislators and policymakers to decriminalize gender affirming care, decrease discrimination and violence against transgender individuals, educate themselves on transgender health-care issues, and recognize that transgender youth health is not a political issue (Abreu et al., 2022).

Physicians, Physician Assistants, and other healthcare professionals need to acknowledge and address the ongoing discrimination that LGBTQ+ people face in healthcare settings. Health professionals need to be prepared to provide competent and high-quality care to LGBTQ+ people. They need to be aware of how health and social disparities, and structural barriers affect the delivery and receipt of care for LGBTQ+ people to actively address these disparities and barriers.

In order to develop policies for the Oregon Medical Association, a workgroup of the Justice, Equity and Diversity Committee reviewed and considered existing policies from the American Medical Association, American Academy of Pediatrics, and the GLMA: Health Professionals Advancing LGBTQ Equality. In addition to examining these policies, the workgroup also reviewed other policies, statements, studies, and resources from state and national medical associations and organizations advocating for LGBTQ+ health.

These recommendations will become OMA policy and allow OMA to advocate, influence, and educate to advance and improve LGBTQ+ healthcare in the state, furthering the OMA’s goals of advocating for an equitable and accessible healthcare environment.

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APPENDIX V

APPENDIX V: TRAINING HEALTH PROFESSIONALS ON LGBTQ+ TOPICS

*GLMA: Health Professionals Advancing LGBTQ+ Equality does not generally spell out the acronym “GLMA” as part of the name since adopting a more inclusive organizational name.

**Using gender-inclusive language means speaking and writing in a way that does not discriminate against a particular sex, social gender or gender identity, and does not perpetuate gender stereotypes. Given the key role of language in shaping cultural and social attitudes, using gender-inclusive language is a powerful way to promote gender equality and eradicate gender bias. (https://www.un.org/en/gender-inclusive-language/)

Comments

Prior studies have indicated that there is a lack of formal LGBTQ+ health training across the Graduate Medical Education (GME) curricula and within the multidisciplinary healthcare team (ACGME, 2020; ACGME 2022a; ACGME 2022b; Gardner et al., 2014; Kortes-Miller, Wilson, & Stinchcombe, 2019). Evidence suggests that medical students may be unprepared to care for LGBTQ+ patients at graduation (Nama et al., 2017; Zelin et al., 2018). Studies further suggest that residents lack competence when caring for LGBTQ+ patients (Streed et al., 2019; Zelin et al., 2019). Surveys of residents across different specialties demonstrate that they feel unprepared and uncomfortable treating LGBTQ+ patients and would like training in LGBTQ+ health topics (Guerrero-Hal, 2021; Hayes et al., 2015; Moll et al., 2019; Roth et al., 2021; Streed et al., 2019).

The absence of formal training results in physicians who have not acquired basic knowledge on LGBTQ+ health topics, which may negatively affect patient care (Hurd, 2015). The need for formal training was demonstrated by a recent study showing that senior residents in internal medicine had poor knowledge about sexual and gender minority health and health disparities, despite several years of residency training (Streed et al., 2021). Basic knowledge of health topics and disparities is necessary for the provision of competent care.

The American Geriatrics Society position statement on care of older LGBTQ+ adults identifies education for healthcare providers on “LGBT health concerns focused on the older adult population, the effect of discrimination on healthcare delivery, the social circumstances of LGBT individuals, and the relationship between social history (including gender identity, relationship status, and sexual behavior) and health and health care” as one of the most important steps for the delivery of high-quality health care (Hurd, 2015). Recently, the American Geriatrics Society has been joined by several medical societies and other members of the Graduate Medical Education (GME) community in calling for training that is responsive to the health needs of the LGBTQ+ community (Hurd, 2015; Pregnall, Churchwell, & Ehrenfeld, 2021; Roth et al., 2021; Streed et al., 2021). Despite these calls, no formal curricula on LGBTQ+ health is required as part of internal medicine residency or geriatric fellowship training (ACGME, 2020; ACGME 2022a, 2022b). Several residency programs have independently developed their own LGBTQ+ curricula (Barrett et al., 2021; Grova et al., 2021; Klein & Nakhai, 2016; Roth et al., 2021; Streed et al., 2021); however, the lack of a formal curricula or guidance from the ACGME, means that residency and fellowship programs incorporate content on LGBTQ+ health topics inconsistently.

Physicians, Physician Assistants, and other healthcare providers have an important role in supporting the health and needs of older LGBTQ+ patients (Hurd, 2015; Maingi et al., 2021). LGBTQ+ patients report feeling more comfortable accessing medical care when their provider is also LGBTQ+ or is familiar with the LGTBQ+ community (Martos et al., 2018; Rossman, Salamanca, & Macapagal, 2017; Rutherford et al., 2012), which is particularly important given the wide health disparities for LGBTQ+ individuals (Gonzales, Przedworkski, & Henning-Smith, 2016). Education in LGBTQ+ health topics is vital for the provision of high-quality and comprehensive healthcare for creating the safe and inclusive environment that patients need to have conversations about their health, goals of care, and end of life decisions (Pecanac, Hill, & Borkowski, 2021).

Healthcare professionals, including physicians and physician assistants, have an obligation to provide high-quality and comprehensive care to all patients, including LGBTQ+ individuals. Support for training, education, and competencies for healthcare professionals related to LGBTQ+ health will help ensure that patients receive the high-quality care they deserve. To assist OMA policy development, this workgroup reviewed and considered existing policies from the AMA and the GLMA: Health Professionals Advancing LGBTQ Equality. In addition to examining these policies, the workgroup also reviewed other policies, statements, studies, and resources from state and national medical associations and organizations advocating for LGBTQ+ health.

These recommendations will become OMA policy and allow OMA to advocate, influence, and educate to advance and improve LGBTQ+ healthcare in the state. These recommendations will further the OMA's goals of advocating for an equitable and accessible healthcare environment and building and supporting the community of physicians and physician assistants.

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APPENDIX W

APPENDIX W: PROTECTING PATIENTS AND THE PRACTICE OF MEDICINE IN A TIME OF DISINFORMATION ABOUT GENDER-AFFIRMING CARE

COMMENTS:

Legislation that intrudes into the practice of medicine and interferes with the patient-physician relationship risks the health and welfare of all patients, but especially of marginalized communities. Major medical associations stand together in opposition to government interference in the patient-clinician relationship and the provision of health care based on the

physician's best clinical judgment and on clinical evidence and the standard of care.24 25 26 27 28 Laws that intrude into the privacy of physician-patient communications "compromise the rights of both patients and physicians" 29 and "compromise the patient-physician relationship which is essential to the provision of safe and quality medical care." 30 Such laws restrict access to care and advance a political or religious agenda at the cost of high-quality medical care and public health. This type of legislation often disproportionately harms women or marginalized groups in our society.

The Oregon Medical Association (OMA) Statement on Gender-Affirming Care has previously stated that "[t]he OMA stands in opposition to any government action that perpetuates any form of discrimination, and specifically we oppose the use of the legislative and legal process to coerce discriminatory behavior from others." 31 In recent years, socio-political discourse has shifted towards political actions targeting transgender people, including their access to healthcare. There has been a particular focus on the decision of clinicians and parents to allow transgender adolescent children to begin medically transitioning.32 Conversations around transgender rights and gender affirming care are occurring in a public and politicized space, without adequate consideration and incorporation of peer-reviewed, scientific knowledge into the formation of opinions and legislation, resulting in dangerous situations for those delivering and receiving care.33 34 35 36 Disinformation, often spreading rapidly on social media, has had an outsized influence on policy decisions despite efforts to combat disinformation by health professionals.37 38 39 Legislative, executive, and judicial actions taking away the rights of transgender people and their access to gender affirming care have continued despite recognition and support of these treatments as the standard of care by major medical associations. Gender affirming care is recognized by major medical organizations to be

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medically necessary and is associated with reductions in suicide and improved quality of life.40 41 42

According to Trans Legislation Tracker, a non-profit dedicated to documenting and bringing awareness to the historic rise in anti-transgender laws, there has been a sharp increase in bills nationwide attacking gender affirming healthcare in 2023 (i.e. from 35 in 2022 to 178 as of October 2023). Of the 85 anti-transgender bills that have become law in 2023, those criminalizing gender affirming care, often under the guise of protecting minors' health or parental rights, make up the largest category.43 In some states, the act of providing what has been shown to be an important part of standard healthcare for this community is proposed to be a felony, legally equivalent to child abuse. 44 45 46 47 The current rescinding of transgender rights and criminalization of gender affirming care is a clear regression of human rights. It is not only reminiscent of laws from the 1950s and 1960s used to justify the arrest of gender non-conforming people48 but also paves the way for the legal subjugation of transgender people, and eventually, threatens their rights and safety when presenting authentically in public. Oregon's new law (as of Summer 2023) expands legal protections for LGBTQ+ people, requiring state Medicaid and some private insurers to cover aspects of gender affirming care, and protects clinicians who render that healthcare.49 50 This is an excellent start to protecting the rights of transgender people. However, it cannot stand alone, especially given the lack of robust federal protections for transgender people, and the scale of anti-transgender sentiment spreading across the U.S.

Bills that aim to suppress gender affirming care and impede the integration of transgender people into public life rely on inaccurate and misleading scientific claims and threaten both transgender patients and the healthcare clinicians and family members that care for them.51 52 The anti-transgender agenda in legislative and political spaces produces wide-spread fear-mongering and hatred in social media and in-person environments.53 54 The spread of disinformation around transgender adults and children, and often drag queens and intersex

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[45] Goodman, J. (2022). How Medical Care for Transgender Youth Became 'Child Abuse' in Texas. The New York Times. Retrieved November 7, 2023; Available from: https://www.nytimes.com/2022/03/11/us/texas- transgender-youth-medical-care-abuse.html

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[47] Ibid.

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[50] Movement Advancement Project. (2023). Oregon's Equality Profile. Retrieved November 7, 2023; Available from: https://www.lgbtmap.org/equality-maps/profile_state/OR

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people concurrently,55 56 is actively harming these marginalized groups that are the targets of an increasing number of hate crimes and are at risk of having their constitutional rights infringed upon.57 Pervasive disinformation surrounding gender affirming care for children and adults is not rooted in factual scientific or medical knowledge, but continues to spread through political commentary disguised as news and on social media and remains a popular source for a portion of the population. Dissemination of messages that lack scientific backing is reminiscent of other recent instances of disinformation that have gained traction, including the beliefs that ivermectin can treat COVID or that vaccines cause autism.58 59 Physicians have an obligation to share evidence-based medicine, as is already recognized by the Oregon Medical Board (OMB) and supported by codified Oregon law.60 The OMB points out that "licensees are respected members of our communities with the power to impact the health and wellbeing of Oregonians. As experts in the field of medicine and health care, they are looked to for advice and guidance, and the public relies on our trusted health care professionals for reliable, unbiased information. OMB licensees are therefore expected to use their voices to share factual, evidence-based information and to correct any misinformation or disinformation that has a potential to harm the public."61

There is also ethical grounding for the protection of gender-affirming care and the clinicians involved in this type of care. At its core, gender-affirming care is aligned with the promotion of human rights and the four principles—autonomy, beneficence, non-maleficence, and justice—as articulated by Beauchamp and Childress over four decades ago. Regarding autonomy, transgender and gender-diverse patients are entitled to rights of self-determination, bodily autonomy, gender expressivity, and informed consent.62 63 The principle of nonmaleficence imbues a negative requirement on clinicians, meaning they must not aid in the propagation of bias, stigma, and misinformation surrounding gender-affirming care. Contrastingly, beneficence imbues a positive requirement, meaning there is both a professional and ethical obligation to actively remove barriers to care, advocate for patient's rights, and challenge generational systems of oppression that disproportionately affect marginalized populations. The final principle, justice, is meant to enshrine equity and accessibility in healthcare; under this view, transgender and gender non-conforming patients are "equally entitled to a fair distribution of healthcare resources."64

Harmful narratives around gender affirming care need to be removed from and corrected in socio-political discussions, and policies around health care decisions should be considered from a medical, scientific, and ethical standpoint by qualified professionals. A concerted response by medical associations, healthcare organizations, hospital leaders, communications staff,

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[64] Hann, M., Ivester, R., & Denton, G. D. (2017). Bioethics in Practice: Ethical Issues in the Care of Transgender Patients. The Ochsner Journal, 17(2), 144–145.

community organizations, and security and law-enforcement agencies; diligent fact checking by responsible journalists; and removal of disinformation by social media platforms is necessary to counter the effects of disinformation.65 The regulations and laws proposed in anti-transgender legislative campaigns are incompatible with the fundamental ethical principles of health professions and the doctor-patient relationship and would subject patients, parents, physicians, and educators to scrutiny associated with criminal penalties.66 67 These actions represent deprivation of rights under color of law and are incompatible with the values and foundational principles of the Oregon Medical Association. The methods of this public and political anti-transgender movement stand as a cautionary example of how discrimination can intrude into health care and distract from the very real and pressing health concerns facing Oregonians and communities across the country. Medical professionals and medical associations are uniquely positioned to counteract disinformation and have an obligation to advocate for all patients' rights and their access to healthcare. These policy recommendations directly support the OMA's mission to promote equitable and accessible healthcare and conserve the ability of physicians and PAs to safely practice medicine.

*** For this reason, some sources cited in this commentary are not from peer-reviewed journals.

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[66] Martin, S., Sandberg, E. S., & Shumer, D. E. (2021). Criminalization of Gender-Affirming Care— Interfering with Essential Treatment for Transgender Children and Adolescents. New England Journal of Medicine, 385(7), 579–581. https://doi.org/10.1056/NEJMp2106314

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APPENDIX X

APPENDIX X: MATERNAL MORTALITY AND MORBIDITY AS A PUBLIC HEALTH CRISIS

OMA Stance and National Implications

The OMA recognizes that maternal mortality and morbidity are of significant concern within Oregon and across the United States. The U.S. continues to fall behind peer countries in maternal health outcomes, with Black, American Indian and Alaskan Native (AIAN) and Native Hawaiian or Pacific Islander (NHPI) patients experiencing disproportionately high rates of maternal mortality.[68] Severe maternal morbidity rates are also higher among historically marginalized communities (with the highest being among Black women) compared to non-Hispanic white (NHW) women.[69] Reproductive health policies and broader systemic factors, including income, housing stability, transportation, and racial disparities, further exacerbate these inequities. Significant shifts in federal policy due to changing government administrations have resulted in deleterious outcomes for patients. The recent overturning of abortion protections granted by *Roe v. Wade* in the 2022 *Dobbs v. Jackson Women's Health Organization* ruling transferred abortion regulatory power to individual states. Texas’s subsequent outlawing of abortion resulted in dramatically increased sepsis rates and mortality for pregnant patients.[70],[71] These complications disproportionally affect communities of color compounding with preexisting disparities.[72] This ruling illustrates the need to protect patient access to safe healthcare and for the OMA to establish policies that address maternal morbidity and mortality, with a focus on historically marginalized communities.

Defining Maternal Mortality and Morbidity

Maternal mortality is a public health crisis in the U.S. There are variations in the definition of maternal mortality, with the CDC and WHO defining it as death “while pregnant or within 42 days of ending of pregnancy, irrespective of the duration, and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[73] The Oregon Health Authority however extends this timeline to include

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deaths within one year following pregnancy.[74] The AMA supports the development of a standardized definition of maternal mortality and increased resource allocation to improve collection and analyze of maternal deaths.[75] As per CDC data, in 2022, the US had 22 maternal deaths per 100,000 live births.[76] Healthcare gaps that result in high maternal mortality rates disproportionately impact communities of color, particularly Black women, and have potentially deleterious downstream effects on newborn health and well-being.[77] The WHO defines maternal morbidity as "any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative impact on the woman's well-being and/or functioning".[78] Maternal morbidity is less researched than mortality, leading the true extent of maternal morbidity to be unknown.

Race Disparities within the United States

Maternal mortality rates fluctuate yearly, with a dramatic increase of 40% from 2020 to 2021 amid the COVID pandemic, but Black women have historically born the greatest burden.[79] Using the WHO definition of maternal mortality, Black women experienced 69.9 maternal deaths/100,000 live births in 2021, and AIAN women had 63.4 maternal deaths/100,000 live births.[80] Although rates decreased the following year in 2022, Black women continued to be disproportionally affected, with 49.5 maternal deaths/100,000 live births, more than double the rate for white woman (19.0 maternal deaths/100,000 live births) [Figure 1].[81] This rate exceeds the combined maternal mortality rates of the next four highest-ranking countries: Chile at 14.3, New Zealand at 13.6, Korea at 8.8, and Canada at 8.4 [Figure 2].[82]

Contributing Causes to Maternal Mortality

Over 80% of U.S. pregnancy-related deaths are preventable[83], illustrating the importance of recognizing both medical and systemic factors that contribute to maternal mortality. While Oregon performs better than the national rate, it was determined that between 2018-2020, 53%

[74] Oregon Health Authority. (2023). January 2023 biennial report: Maternal mortality review committee (MMRC). Retrieved from https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/January2023BiennielReportMMRCFinal.pdf . Accessed March 25, 2025.

[75] American Medical Association. (n.d.). Reducing inequities and improving access to insurance for maternal health care (H-185.917). Retrieved from https://policysearch.ama-assn.org/policyfinder/detail/%22Reducing%20Inequities%20and%20Improving%20Access%20to%20Insurance%20for%20Maternal%20Health%20Care%20%20H-185.917%22?uri=%2FAMADoc%2FHOD.xml-H-185.917.xml. Accessed March 25, 2025.

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of pregnancy-related deaths were preventable in Oregon.[84] Black women and other women of color experience higher rates of pregnancy complications and mortality due in part to underdiagnosed chronic conditions, lack of a clinical protocol for identifying high-risk pregnancies, and inequitable treatment of these conditions.[85] For example, Black women frequently have higher risk for cardiovascular disease and are more likely to experience severe peripartum cardiomyopathy and end-organ damage due to hypertension with variable responses to hypertensive treatment compared to NHW women[85]85. Additionally, when compared to NHW women, “Black, AIAN, and NHPI women have higher shares of preterm births, low birthweight births, or births for which they received late or no prenatal care.”[86]

Maternal outcomes are also impacted by health determinants, which include individual behaviors, lifestyles, response to stress, genetics, epigenetics, clinical events, and social determinants such as economic stability, transportation access, and proximity to healthcare facilities.[87] In the U.S., many regions lack access to an adequate number of maternity care providers, such as physicians, PAs, midwives, and doulas, leading to “maternity care deserts”.[88] This requires patients to travel long distances for basic obstetric care, something that many may not be able to do. The AMA supports promoting telehealth and home monitoring as a solution to provide remote patient care during and after pregnancy.[89] A lack of insurance and inadequate coverage from prenatal care through postpartum follow-up also contributes to high maternal mortality and morbidity rates in the United States .[90] According to the 2021 U.S. Census Bureau, people of color are more likely to be uninsured than NHW individuals, making them particularly vulnerable to gaps in maternal care.[91]

Structural racism and implicit bias within healthcare also contribute to poorer health outcomes for communities of color. Structural racism is described as the way systems - like housing, education, employment, media, criminal justice - reinforce discriminatory beliefs which then shape how resources are distributed.[92] Implicit biases are subconscious assumptions and behaviors about a group of people, often stemming from a lack of cultural understanding and education on the impact of disparities on health.[92] The impact of structural racism and implicit bias is evident, as even when controlling for socioeconomic status and comorbidities, non-Hispanic Black women experience higher pregnancy-related complications compared to NHW

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[84]*Oregon Maternal Mortality and Morbity Review Committee Biennial Report*. (2023). Retrieved from https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/January2023BiennielReportMMRCFinal.pdf

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[92]Montalmant, K.E., Ettinger, A.K. The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. J. Racial and Ethnic Health Disparities 11, 3658–3677 (2024). https://doi-org.proxy.westernu.edu/10.1007/s40615-023-01816-x

women.[92] Implicit bias can lead to microaggressions and discrimination, creating an environment that feels unsafe and furthering mistrust in medical systems, ultimately discouraging people from seeking care. Addressing these disparities to improve maternal outcomes requires improving patient-provider relationships through increased cultural humility training and disparity education for health care professionals.[92]

Strategies to Reduce Maternal Mortality Rates

A multifaceted approach is critical to improving patient care, with the goal of decreasing maternal mortality rates, and giving special attention to the unique disparities communities of color face. Key strategies should include:

1. Improving Access to Quality Healthcare: Ensuring that high-quality prenatal and postpartum care is accessible for all patients that need it is crucial. This includes expanding Medicaid coverage to cover the entire 1-year postpartum period, which was enacted by the Oregon Health Authority in 2022.[93] Medicaid expansion is linked to increased access to care, improved health outcomes, and reductions in racial disparities in healthcare.[94]
2. Addressing Racism and Implicit Bias: Training healthcare providers to recognize and address their own implicit biases, with the goal of lifelong work to equitable care, can improve quality of care that patients receive, especially those from historically marginalized groups[95] and utilizing medical-legal partnerships to help health care providers and systems address the root causes of poor health outcomes[96].
3. Medical Representation: Systemic factors, including racism, contribute to underrepresentation of certain races and ethnicities in the medical field. Patients of color are more likely to report lower quality patient-physician communication and participatory decision making when receiving care from racially discordant physicians.[97] Conversely, a study of hospital births in Florida found that newborn-physician race concordance was associated with a decrease in mortality of Black infants.[98] Improving the recruitment and retention of clinicians from underrepresented communities not only improves the ability of healthcare to care for diverse patients but also improves patient outcomes.[99]
4. Enhancing Community Support: Strengthening community-based programs that provide support and health education can help improve outcomes. These programs can offer additional resources such as doulas, who contribute to the interprofessional maternity care team by providing continuous support during pregnancy, childbirth, and even

[93] Inbody, D. (2022). *12-month eligibility for Oregon Health Plan post-partum benefits*. Retrieved from https://www.oregon.gov/oha/HSD/OHP/Announcements/12-month%20eligibility%20for%20Oregon%20Health%20Plan%20post-partum%20benefits.pdf

[94]Racial and Ethnic Inequities in Obstetrics and Gynecology. (2024). Retrieved March 25, 2025, from Acog.org website: https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2024/09/racial-and-ethnic-inequities-in-obstetrics-and-gynecology

[95]Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. J Womens Health (Larchmt). 2021;30(2):230-235. doi:10.1089/jwh.2020.8882

[96]Home -- National Center for Medical-Legal Partnership. (n.d.). Retrieved March 26, 2025, from Medical-Legal Partnership website: https://medical-legalpartnership.org/

[97]Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. J Racial Ethn Health Disparities 2018; 5: 117– 40. doi: 10.1007/s40615-017-0350-4

[98] Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. Proc Natl Acad Sci U S A 2020; 117: 21194– 200. doi: 10.1073/pnas.1913405117

[99]St. George's University. (2018, December 17). The Importance of Diversity in Health Care. Retrieved March 26, 2025, from Sgu.edu website: https://www.sgu.edu/blog/medical/pros-discuss-the-importance-of-diversity-in-health-care/

postpartum care.[100] To improve postpartum care, Oregon is the first state that established Family Connects Oregon, a universally offered nurse home health visiting service for all families with newborns up to 6 months old.[101]

5. Research and Data Collection: Increasing research on public health disparities, including Black, AIAN, and NHPI maternal mortality and morbidity rates, allows for comprehensive data collection to identify the specific needs and challenges faced by these women, thus informing more targeted interventions.[102] The AMA also encourages state and county health departments to create maternal mortality surveillance systems.[103] Oregon established the Oregon Maternal Mortality and Morbidity Review Committee (MMRC) in 2018, which publishes a biennial report on maternal mortality and morbidity in Oregon.[41]
6. Mental Health Services: In Oregon from 2018-2020, the most frequent cause for underlying cause of maternal death was mental health conditions, including substance use disorder (41%).[104] The shortage of mental health providers, insurance barriers, language differences, and geographical distances are some contributing factors of inadequate mental health services.[104] Oregon's MMRC recommends that actions are taken to ensure access to mental health services and substance use disorder services for pregnant and postpartum people, with a focus on the BIPOC community.[104]
7. Policy Reformation: Implementing policies that screen for and address social determinant of health, by improving economic stability and access to education and housing, can help reduce disparities. This includes advocating for paid family leave and affordable childcare.[105]
8. Public Awareness and Advocacy: Raising awareness about maternal mortality and its disparities with the goal of advocating for systemic changes can help drive policy reforms and increased support for impacted communities.[102] It is crucial that this advocacy centers on engaging individuals with lived experiences of marginalization, whose personal expertise will guide change.[106]

Conclusion

By addressing these areas of concern, we can work towards reducing the disparities in maternal health outcomes and ensuring that all women receive the care and support they need. These resolutions are supported in part by the American College of Obstetricians and Gynecologists and Oregon's MMRC.[104,106]

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[100]Improving Maternal and Infant Health Through Multisector, Community-Driven Partnerships. (2024). *Commonwealthfund.org*. https://doi.org/10.26099/rfyp-4k12

[101]Oregon Health Authority : Family Connects Oregon : Home Visiting : State of Oregon. (n.d.). Retrieved March 26, 2025, from Oregon.gov website: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HOMEVISITING/Pages/Family-Connects-Oregon.aspx

[102]Purandare, R. (2023, August 10). Addressing Maternal Mortality Through Improved Data Collection and Access | AcademyHealth. Retrieved March 26, 2025, from academyhealth.org website: https://academyhealth.org/blog/2023-08/addressing-maternal-mortality-through-improved-data-collection-and-access

[103]Policy Finder | AMA. (2025). Retrieved March 26, 2025, from Ama-assn.org website: https://policysearch.ama-assn.org/policyfinder/detail/Maternal%20Morbidity?uri=%2FAMADoc%2Fdirectives.xml-0-1423.xml

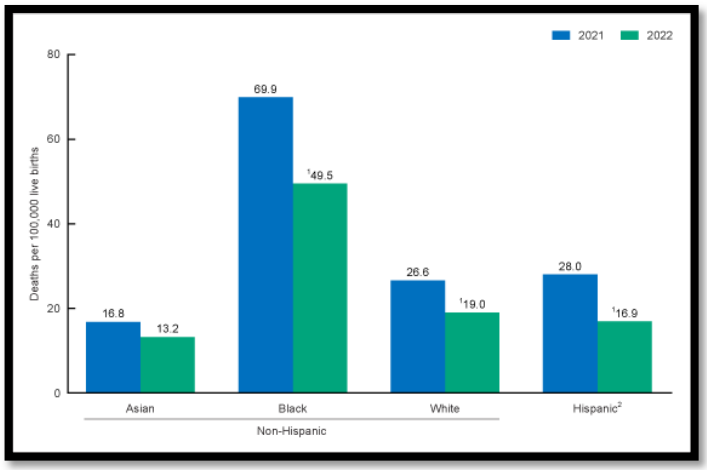
[104]*Oregon Maternal Mortality and Morbity Review Committee Biennial Report*. (2023). Retrieved from https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/January2023BiennielReportMMRCFinal.pdf

[105]Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. J Womens Health (Larchmt). 2021;30(2):230-235. doi:10.1089/jwh.2020.8882

[106]Racial and Ethnic Inequities in Obstetrics and Gynecology. (2024). Retrieved March 25, 2025, from Acog.org website: https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2024/09/racial-and-ethnic-inequities-in-obstetrics-and-gynecology

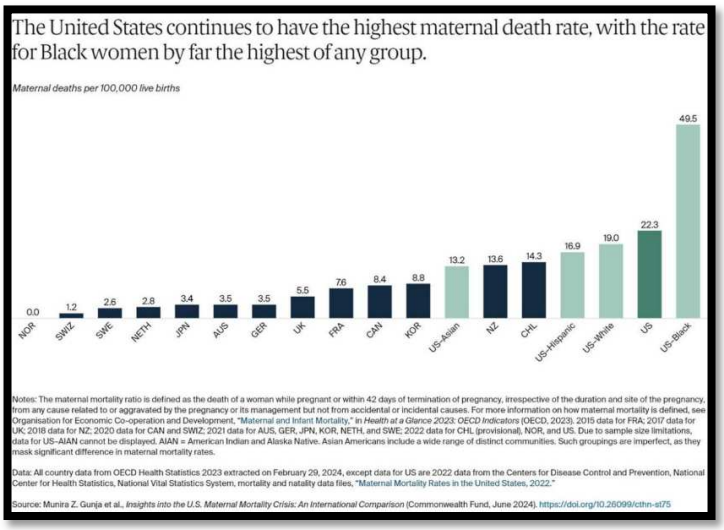
Greater than 80% of pregnancy related deaths were preventable.[107] Access to adequate healthcare improves health outcomes for pregnant mothers. Structural racism and implicit bias contribute to the disparate maternal mortality outcomes for Black, AIAN and NHPI mothers. Strategies to implement culturally humility have been shown to improve health outcomes for pregnant women. Health determinants have a significant negative impact on maternal health outcomes. Strategies that directly address health determinants, such as medical-legal partnerships[10852], can support pregnant and postpartum mothers by providing legal assistance to address issues that may impact their health including housing, eviction, food insecurity, medication access and health insurance coverage, or other financial challenges.

Figure 1: "Maternal mortality rate, by race and Hispanic origin: United States, 2021 and 2022"



[109]

Figure 2



[107] CDC. (2024, September 25). Preventing Pregnancy-Related Deaths. Retrieved March 26, 2025, from Maternal Mortality Prevention website: https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html

[108] AMA recommendations to improve maternal health outcomes. (2024, August 30). Retrieved March 26, 2025, from American Medical Association website: https://www.ama-assn.org/delivering-care/public-health/ama-recommendations-improve-maternal-health-outcomes#

[109]Hoyert, D. (2024, May 2). Maternal Mortality Rates in the United States, 2022. Retrieved from www.cdc.gov website: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm

APPENDIX Y

APPENDIX Y: UNIVERSAL HEALTHCARE AND HEALTH COVERAGE - 2024

COMMENTS:

In 2018, the OMA Executive Committee approved creation of a limited duration task force to address previously submitted policy resolutions regarding universal access to healthcare in Oregon, single payer healthcare, and the provision of universal health care. The Task Force developed recommendations including a position statement and principles around the provision of universal healthcare and recommended adoption in place of policy resolutions. Those recommendations were adopted in 2018 and became OMA policy.

In 2023, the Justice Equity Diversity and Inclusion Committee started its review of all existing OMA policy (Where We Stand), section by section to recommend updates using a lens of equity. Among the policies were the position statement and principles around the provision of universal healthcare.

A limited duration workgroup was assembled, made up of members representing the Justice Equity Diversity and Inclusion Committee, the Legislative Committee, and the Policy Committee. The workgroup was chaired by Policy Committee chair, Dr. Robert Orfaly and JEDI Committee co-chair, Dr. Fred Williams. There were a few members who had been members of the original task force.

There were several reasons why the timing was essential to review, and potentially revise, the principles now, only five years later.

1. As mentioned earlier, the OMA was reviewing all current policies using an equity lens.

2. Health disparities, and issues of health inequity, though present earlier, were magnified during and following the COVID-19 pandemic. The weaknesses of the medical system regarding health equity were brought to the forefront.

3. George Floyd's death and other events in 2020 amplified how racial injustice contributes to health inequities.

4. Senate Bill 770, passed by the Oregon Legislature in 2019 created a Task Force on Universal Health Care. That Task Force, charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents, submitted its final report in September 2022. OMA wanted its principles to be updated if needed as we respond to the work that comes from this task force.

The OMA Universal Access Workgroup will continue its work following these recommendations by examining the work of the state's Task Force on Universal Health Care.

APPENDIX Z

APPENDIX Z: PERSON-CENTERED LANGUAGE IN MEDICAL RECORDS

COMMENTS:
Language used to describe patients in medical documentation can perpetuate bias, influence clinical decision-making, and contribute to healthcare disparities.[1] Language and communication about our patients must align with our commitment to equitable, patient-centered care. The Oregon Medical Association (OMA) strongly endorses the use of person-first, equity-focused language in patient medical records. Our stance reflects a commitment to ensuring that all individuals are treated with dignity, respect, and humanity. Person-first language in healthcare prioritizes the individual over their condition, aiming to treat patients with respect and reduce stigma emphasizing their humanity and discouraging bias.

The Impact of Stigmatizing Language in Medical Records
Research demonstrates that stigmatizing language in medical records such as "non-compliant" or "substance abuser," negatively impact the attitudes and behaviors of clinicians, perpetuating bias and reducing the quality of care. Such language may transmit and reinforce these biases amongst other clinicians and potentially affect treatment decisions.[2] When stigmatizing language is present in medical documentation, clinicians are more likely to form negative attitudes toward the patient, offer less aggressive pain management, and make punitive judgments.[2]

Person-First Language for Health Equity
OMA advocates for person-first language in medical records to counter these negative biases. This approach emphasizes the person before the diagnosis or condition, helping to preserve the patient’s dignity and avoiding the depersonalization often caused by labels. For example, rather than referring to a patient as a "diabetic" or a "substance abuser," we encourage clinicians to describe the patient as "a person living with diabetes" or "a person with a substance use disorder." This subtle shift in language fosters more compassionate care and aligns with the OMA goal of reducing health disparities.

It is also essential to recognize that while person-first language is generally appropriate, certain individuals may prefer identity-first language. For example, individuals within the autistic and deaf communities may opt for terms such as 'Autistic person' or 'Deaf person,' reflecting a sense of identity and culture. Preferences can vary even within communities, underscoring the need for clinicians to engage in patient-centered communication and inquire about individual language preferences to ensure respectful and personalized care.[3]

Avoiding Blame and Bias in Documentation
Stigmatizing language, such as terms like "non-compliant" or "uncooperative" often places undue responsibility or blame on patients for their health conditions without considering external factors, such as social determinants of health. This language can overlook barriers such as transportation, financial challenges, or access to healthcare and undermine trust between patients and clinicians.

OMA advocates for documentation practices that recognize the structural barriers affecting patients' choices. For instance, instead of labeling a patient as "non-compliant," clinicians could

document, "Patient unable to attend clinic due to lack of transportation." This allows healthcare teams to better understand and address the root causes of health inequities and promotes solutions-oriented care.

As medicine shifts towards a collaborative, patient-centered model, clinicians should use language that supports and respects patient autonomy. Communication should refrain from conveying personal disapproval of patient choices or unnecessarily questioning their credibility, ensuring interactions that empower and validate patients' perspectives and lived experiences.

Reducing the Transmission of Bias

Medical records serve as the primary communication tool among clinicians. The language used within them can perpetuate bias across care teams, disproportionately impacting economically or socially marginalized communities. Patients of color, especially Black patients[4], are disproportionately more likely to have stigmatizing language documented in their records. Such language can lead to diminished trust, compromised patient and healthcare team relationships, and poorer health outcomes[5]. Using respectful, objective language minimizes the transmission of bias and ensures that care is fair, equitable, and free from stigma.

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APPENDIX AA

APPENDIX AA: HEALTHCARE DELIVERY AND ADVOCACY FOR PERSONS EXPERIENCING HOMELESSNESS

Introduction

Patterns of disease among People Experiencing Homelessness or Houselessness (PEH) differ from the general population. The average age of death for unsheltered PEH is approximately 47 years [110]. Suffering on the streets, moreover, goes beyond the physical. Moral injury, while not widely studied, is likely to be significant on the streets. Factors such as high rates of trauma

[110] Rabell L. Mortality and homelessness fact sheet. National Health Care for the Homeless Council. December 5, 2024. Accessed March 25, 2025. https://nhchc.org/resource/mortality-and-homelessness-fact-sheet/.

exposure, PTSD and social isolation are considered correlates to moral injury111112. PEH commonly express feelings of invisibility, of not being heard. The OMA believes it is a responsibility of society to both deliver quality healthcare and advocate for PEH and public health. This type of legislation often disproportionately harms women or marginalized groups in our society.

Access to high-quality healthcare, independent of housing status or stability
PEH have unique healthcare needs. The American College of Physicians acknowledges this, citing the difficulty of managing chronic illness without consistent medication storage, disproportionate exposure to infectious disease and extreme weather, the stress and trauma inherent to the experience of becoming unhoused, and the simple fact that "injuries and minor illnesses can easily worsen without a safe and clean place to rest and recuperate."[113]

PEH additionally face enormous economic and social barriers to accessing healthcare. This is true in Oregon despite comparatively high rates of medical insurance.[114][115] PEH often lack consistent access to network-enabled smartphones and charging equipment, making signing up for and maintaining Oregon Health Plan coverage onerous. Attending appointments can also prove extraordinarily difficult: PEH often reside far from public transit corridors to avoid "sweeps" (forced relocations), lack access to transit fare, and risk permanently losing their possessions if their camp is "swept" in their absence. On arrival at their clinic, the stigmatization of PEH in healthcare settings is a well-known phenomenon: a 2020 systematic review found studies reporting on discrimination, paternalism and humiliation, dehumanization, and even loss of freedom experienced by PEH in clinical settings.[116] Individually and together, these experiences can lead PEH to avoid healthcare, even with emergent symptoms.

Given these challenges, strong patient care for PEH involves both improving access to care in traditional medical settings and supporting patients through the use of outreach teams, often popularly known as "street medicine." Street medicine programs have been shown to be beneficial both to individual patients and to the overall health of our medical system[117]. The American Medical Association (AMA) supports the use of funds, including Medicaid and other public insurance reimbursement, for the maintenance of these programs.[118] Medicaid's new Place-of-Service code,[119] moreover, allows for billing of services in non-traditional settings. Active support of street medicine programs and traditional clinics serving PEH thus benefits

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[111] Serchen J, Hilden DR, Beachy MW; Health and Public Policy Committee of the American College of Physicians. Meeting the Health and Social Needs of America's Unhoused and Housing-Unstable Populations: A Position Paper From the American College of Physicians. Ann Intern Med. 2024 Apr;177(4):514-517. doi: 10.7326/M23-2795. Epub 2024 Feb 27. PMID: 38408358.
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[119]CMS Code Change Bolsters Street Medicine programs | healthcare innovation. Accessed March 25, 2025. https://www.hcinnovationgroup.com/population-health-management/complex-care/article/53074284/cms-code-change-bolsters-street-medicine-programs.

individual patients, reduces overall system costs, and helps ensure clinicians are meeting their ethical and moral responsibilities to ensure that quality, evidence-based patient care is not conditional, but universal.

Social Determinants of Health and the Impact of those living on the streets
Emerging evidence demonstrates that "Housing First" models are more effective models of care for PEH than previously standard "Treatment First" approaches. Treatment First requires individuals to be in psychiatric treatment and substance-free prior to receiving permanent housing, whereas Housing First provides permanent housing and support services without requiring adherence to psychiatric treatment or abstinence from substance use. A systematic review of 26 studies in the US and Canada found that Housing First decreased homelessness by 88%, leading to downstream benefits such as reduced emergency department use and hospitalizations.[120] Housing First is a cost-effective approach that has also demonstrated reduced substance use, improved mental health treatment engagement, and decreased arrests.[121] Thus, the OMA stands in accordance with the research and policies from the AMA, American Association of Family Physicians, and American Psychiatric Association, all of which endorse a Housing First model. [122,123,124,125]

Involuntary displacement, also called forced relocations or "sweeps," forces PEH to relocate to a new area with no effort to address the barriers they face. Sweeps have many negative impacts, leading to further instability for people already experiencing significant insecurity. Individuals who are involuntary displaced have higher odds of experiencing violence and life-threatening adverse outcomes, losing personal belongings (including medical items, which can lead to poorer health outcomes), and contracting infectious diseases[126][127][128]. Recommended alternatives to sweeps include permanent supportive housing, temporary shelters, sanctioned encampments with services, and storage facilities for PEH.[129] These more compassionate approaches focused on coordinating services and individualized help have proven successful in creating pathways to social assistance. In Philadelphia, for example, an encampment pilot program focused on building relationships with encampment residents has found success through making regular offers of housing, clearly communicating a closure deadline at least 30

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days prior to closure, and providing free storage containers for personal belongings.[130] Strategies such as these minimize the disruption and adverse health outcomes that PEH experience when forced to relocate.

Given the many barriers that prevent PEH from accessing healthcare, leading to worse health outcomes, it is vital to meet patients where they are. Mobile team-based medical outreach programs, also called street medicine, help bridge these care gaps by providing free behavioral health, primary care, and social services to PEH where they live. These programs have been shown to improve access to care and decrease emergency department visits and hospitalizations, while increasing cost savings,[131]

While mobile outreach programs for PEH help improve health outcomes, it is also critical to address the challenges PEH face when discharged from the hospital. Hospital discharge is focused on sending patients to a fixed address, which many PEH do not have. Inadequate discharge planning for PEH can result in care gaps, difficulty with medication adherence, and further burden on emergency departments due to frequent readmissions.[132] Discharge planning should leverage available community resources and enhanced communication between hospitals, shelters, and medical respite to coordinate appropriate long-term housing options for PEH.[133]

Differing Patterns of Disease in the Homeless and Houseless Community
Very little is published on the prevalence and effectiveness of educational curricula in the care of PEH. Inconsistent education suggests that many providers lack the foundational training required to provide consistent, high-quality care for PEH. In November 2021's AMA Journal of Ethics, Withers and Kohl published a concise review of practices and recommendations on the incorporation of street medicine into medical education.[134] In 2020, Canadian researchers developed the Homeless Health Curriculum Framework, centering on core competencies including communication, advocacy, leadership, and understanding of upstream causes. The framework aims to inform design, delivery, service learning, and evaluation for medical school curricula.[135]

Medical education doesn't cease upon graduation. We applaud efforts to educate physicians to address the needs of marginalized populations, such as Oregon's 3-hour Cultural Competency licensure requirement. As prevalent as homelessness is today, we endorse the implementation of CME to assist providers in caring for PEH, as supported by AMA policy.[136,137]

Practices such as street medicine and shelter-based care should be offered in medical school and PA training. The arguments for these educational experiences are threefold. First, early

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exposure to these practices promotes communication and active listening, inspiring the trainees to be more empathetic both to PEH and all other patients. Second, educational experiences less encumbered by administrative tasks allows students to appreciate healthcare delivery that is patient centered and direct, likely mitigating burnout. And finally, there is evidence that PEH and students can collaborate, thus lessening medical trauma and improving the lives of PEH.[138]

Finally, innovative, non-traditional experiences such as community forums or peer-based partnerships are effective in building relationships, improving outcomes and enhancing the educational experience.[139]

Patient right to self-determination in medical or health-related decision-making
While it is difficult to obtain exact rates of substance use disorder among PEH, available data suggest PEH and other vulnerably housed populations experience higher rates of substance use than their counterparts with secure housing.[140] Substance use disorder can be more difficult to overcome for PEH due to limited access to treatment, fewer social supports, a higher prevalence of co-occurring mental health disorders, and the way substances can provide a sense of safety and serve as a coping strategy for the overwhelming stressors of homelessness.[141] Harm reduction approaches have been developed to mitigate the adverse consequences of substance use and are particularly helpful for PEH with concomitant substance use disorders. Approaches include medications for treating substance use disorders, opioid overdose response with naloxone, supervised consumption facilities, managed alcohol programs, and needle exchanges.[142] A systematic review found that harm reduction interventions reduced public injecting, other high-risk consumption methods, and morbidity and mortality associated with substance use.[143] Harm reduction services can also act as a bridge to engagement in healthcare and other social services.[144] The AMA supports harm reduction initiatives and promotes education on harm reduction methods.[145]

Oregon has a long history of advocacy and outreach, and much has been learned from this work including the value of patient-centered approaches. Simply put, outcomes must be guided by quality of life, not length of life or disease cure. This approach, by necessity, can result in patient decisions that seem unwise or certain to result in illness, pain, or death from a purely clinician standpoint. Decisions like these are difficult to witness. A simple acknowledgement that this is part of the work and not unprecedented can ease inevitable moral discomfort for the

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[138]King, C., Fisher, C., Johnson, J. et al. Community-derived recommendations for healthcare systems and medical students to support people who are houseless in Portland, Oregon: a mixed-methods study. BMC Public Health 20, 1337 (2020). https://doi.org/10.1186/s12889-020-09444-4

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[140]National Coalition for the Homeless. Substance abuse and homelessness. Published June 2017. https://nationalhomeless.org/wp-content/uploads/2017/06/Substance-Abuse-and-Homelessness.pdf

[141]National Coalition for the Homeless. **Substance abuse and homelessness.** Published June 2017. https://nationalhomeless.org/wp-content/uploads/2017/06/Substance-Abuse-and-Homelessness.pdf

[142] Magwood O, Salvalaggio G, Beder M, Kendall C, Kpade V, Daghmach W, Habonimana G, Marshall Z, Snyder E, O'Shea T, Lennox R, Hsu H, Tugwell P, Pottie K. The effectiveness of substance use interventions for homeless and vulnerably housed persons: A systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder. PLoS One. 2020 Jan 16;15(1):e0227298. doi: 10.1371/journal.pone.0227298. PMID: 31945092; PMCID: PMC6964917

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[145] American Medical Association. Prevention of Drug-Related Overdose D-95.987. AMA PolicyFinder. Updated 2024. Accessed March 2, 2025. https://policysearch.ama-assn.org/policyfinder/detail/D-95.987?uri=%2FAMADoc%2Fdirectives.xml-0-2069.xml

clinician. In the end, the patient guides the team, and we are there to support the patient throughout the illness, to reduce harm wherever possible.

PEH with terminal or long-term debilitating medical conditions

We acknowledge that PEH are especially vulnerable to inadequate discharge plans from inpatient care. Innovative healthcare delivery models such as medical respite have been shown to lessen morbidity in PEH.[146] AMA policy supports further funding and standardization of respite for PEH.[147]

Palliative care and hospice services are also largely inaccessible to people without permanent residence[148] despite the development of effective, innovative programs,[149,150] Given that hospice services are delivered to where an individual resides and requires a place for safe storage of medical supplies and medications, a lack of stable housing proves to be a large barrier for providing these services. Additionally, without knowing where someone lives there is an inability to provide 24 hour care, provide medical supplies and deliver controlled substances, which must be sent through the mail and be signed for. The unique prescribing needs of people with Substance Use Disorder Syndrome presents an additional barrier to palliative/ hospice care for many PEH[151]

Estimates of the prevalence of disability among PEH range from 30-80%, with a 75% reported rate in Multnomah County by the 2017 Lund report.[152] Healthcare teams must be familiar with the Americans with Disabilities Act (ADA)[153] and advocate for those with both visible and invisible disabilities. For example, the act of moving one's home and belongings can take days. The ADA specifically expects that "reasonable accommodation requests" be fulfilled; medical care facilities and public services must adhere to both the letter and the intention of the law.

Providing care for PEH and the possibility of clinician burnout

The potential impact of working with people who have experienced trauma has been recognized in medical literature as a form of vicarious trauma.[154,155] PEH, meanwhile, are significantly more likely to have experienced trauma than the general public, via both Adverse Childhood

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[146]David Buchanan, Bruce Doblin, Theophilus Sai, and Pablo Garcia: The Effects of Respite Care for Homeless Patients: A Cohort Study, American Journal of Public Health 96, 1278_1281, https://doi.org/10.2105/AJPH.2005.067850

[147] American Medical Association. Eradicating Homelessness H-160.903. Published 2023. Accessed March 2, 2025. https://policysearch.ama-assn.org/policyfinder/detail/homeless?uri=%2FAMADoc%2FHOD.xml-0-718.xml

[148] de Veer, A.J.E., Stringer, B., van Meijel, B. et al. Access to palliative care for homeless people: complex lives, complex care. BMC Palliat Care 17, 119 (2018). https://doi.org/10.1186/s12904-018-0368-3

[149]Jensen, Francine Bench PhD, RN; Thorpe, Deborah PhD, APRN. Social Model Hospice: Providing Hospice and Palliative Care for a Homeless Population in Salt Lake City, Utah. Journal of Hospice & Palliative Nursing 26(2):p 91-97, April 2024. | DOI: 10.1097/NJH.0000000000001000

[150]University of Washington Medicine. Palliative care for the homeless. Accessed March 16, 2025. https://www.uwmedicine.org/specialties/palliative-care/homeless-care

[151]Klop, H.T., de Veer, A.J., van Dongen, S.I. *et al.* Palliative care for homeless people: a systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. *BMC Palliat Care* 17, 67 (2018). https://doi.org/10.1186/s12904-018-0320-6

[152]Schmid T. Multnomah County homeless count reveals nearly 3 in 4 unhoused report disabilities. The Lund Report. June 21, 2017. Accessed March 16, 2025. https://www.thelundreport.org/content/multnomah-county-homeless-count-reveals-nearly-3-4-unhoused-report-disabilities

[153] U.S. Department of Justice. Americans with Disabilities Act of 1990, as Amended. Accessed March 16, 2025. https://www.ada.gov/law-and-regs/ada/

[154] Isobel S, Thomas M. Vicarious trauma and nursing: An integrative review. Int J Ment Health Nurs. 2022 Apr;31(2):247-259. doi: 10.1111/inm.12953. Epub 2021 Nov 19. PMID: 34799962.7.

[155] Søvold LE, Naslund JA, Kousoulis AA, Saxena S, Qoronfleh MW, Grobler C, Münter L. Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority. Front Public Health. 2021 May 7;9:679397. doi: 10.3389/fpubh.2021.679397. PMID: 34026720; PMCID: PMC8137852

Experiences (ACEs)[156] and traumas specific to the experience of homelessness and houselessness.

It comes as no surprise, then, that a study of professionals working with PEH found that "homeless clients often have experienced high levels of trauma, with histories of child abuse, domestic violence, violent crime, and war; these stories are often disclosed to frontline workers… constant exposure to trauma can lead to a normalization of the trauma in frontline workers and can reduce their empathy for their clients and others."[157]

Healthcare professionals (HCP) who specialize in working with PEH, then, are more likely to experience vicarious trauma. Beyond this, HCPs working with PEH observe the trauma inherent to being unhoused: complex social issues made worse by a direct lack of resources and, sometimes, mental health and/or substance abuse issues. HCPs must confront the moral injustices of "sweeps", harassment by law enforcement,[158] and extreme inequality more than many of their colleagues, and must often reckon with our inability to prescribe the medicines many PEH truly require: housing, food, and social support. As PEHs are at a high risk of death, HCPs working with them are also more likely to confront the deaths of their patients.

This work is challenging, requiring HCPs to "listen, reflect, provide support, and assist in problem solving and behavioural change while maintaining an attitude of hope, respect and optimism. However, maintaining a positive approach can be difficult as progress is often slow… may involve relapses, especially where addictions play a role."[159]

One single-city study of frontline workers (both healthcare and non-healthcare) found that 23% of workers suffered from burnout and compassion fatigue, and 30.6% experienced PTSD symptoms.[160]

It falls on healthcare organizations, then, to ensure that clinicians working with PEH have training appropriate to perform their role well, up-to-date knowledge of local resources to better assist patients, and mental health support to ensure provider well-being.

The ability to adequately and easily connect patients experiencing homelessness and houselessness to service organizations and nonprofits makes clinical encounters more effective and helps avoid provider burnout. Healthcare organizations should take an active role in helping to curate and update easily usable guides or databases for HCPs to use in connecting patients to services.

Beyond the clinic, various interventions have shown promise in preventing and mitigating provider burnout,[161]including trauma-informed mental health resources, peer support groups, and debriefing sessions. Institutions should work to make these resources available to clinicians, and to integrate them within paid work hours so that the burden is not placed on caregivers to pursue them outside of service hours.

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[156] Adverse childhood experiences and homelessness: advances and aspirations
Koh, Katherine A et al. The Lancet Public Health, Volume 6, Issue 11, e787 - e788
[157]Dadani, Aliza. "BURNOUT AND PTSD IN WORKERS IN THE HOMELESS SECTOR IN Edmonton," 2016.
[158] NHLC Statement on Police Brutality Against People Experiencing Homelessness. *National Homelessness Law Center.* https://homelesslaw.org/criminalization/police-brutality-statement/.
[159,160] Dadani, Aliza. "BURNOUT AND PTSD IN WORKERS IN THE HOMELESS SECTOR IN Edmonton," 2016.

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APPENDIX AB

APPENDIX AB: DISABILITY POLICIES

Number 1 - Definition of Disability

The Americans with Disabilities Act (ADA) of 1990 defines a person with a disability as someone who:

- has a physical or mental impairment that substantially limits one or more major life activities,
- has a history or record of such an impairment (such as cancer that is in remission), or
- is perceived by others as having such an impairment (such as a person who has scars from a severe burn but is wrongly assumed to have a disabling condition because of those scars),

Therefore, the definitions protect these individuals by law[162].

However, the OMA, in line with the American Medical Association and World Health Organization, chooses to view disability through the biopsychosocial model. This model redefines and reframes disability by focusing on the context people find themselves in rather than the medical model, which focuses on "normal" vs "abnormal" and frames an individual's disability as the problem[163].

The biopsychosocial model defines disability based on:

- biological sources of impairment: physiological or anatomical characteristics of an individual.
- psychological coping strategies and sources of impairment: How an individual's thoughts, emotions, and behaviors influence their experience of disability.
- social structures that turn impairment into disability: environmental and societal barriers (or facilitators) that affect an individual's participation and well-being.

This model forms the basis of the International Classification of Functioning, Disability and Health (ICF), the WHO framework for measuring health and disability at individual and population levels[164]. The ICF is a universal classification system of disability and health for use in health and health-related fields, and acknowledges that every human may experience a decline, temporary or permanent, in health and therefore experience disability[165]. The OMA's definition of disability is informed by the ICF framework, though is not limited to it. While the ICF provides a clinically grounded model, it lacks the principles of intersectionality.

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[162] U.S. Department of Justice Civil Rights Division. Introduction to the Americans with Disabilities Act. ADA.gov. Published 2025. https://www.ada.gov/topics/intro-to-ada/

[163] 2024-2025 AMA Organizational Strategic Plan to Advance Health Equity S2.1.; 2024. https://www.ama-assn.org/system/files/health-equity-ableism-primer.pdf

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Recognizing that disability is dependent on context and that accessibility (or lack thereof) affects outcomes, OMA also recognizes that health disparities among people with disabilities cannot be fully addressed without acknowledging the additional barriers faced by those with intersecting marginalized identities, such as race, ethnicity, gender identity, sexual orientation, age, and behavioral health diagnoses[166],[167],[168]. Whether the individual is a clinician or patient, whether a disability is well-documented in the medical record or not, whether a disability is permanent or temporary, and whether their disability is visible or invisible, the OMA is shifting focus from a person's disability to the medical, social, and structural solutions which improve the overall health and well-being of people living with a functional difference.

In acknowledging the limitations of the ADA and the expanded understanding of disability by national and international health organizations under the biopsychosocial model, the OMA aims to protect the rights and opportunities of individuals living with all types of disabilities. Ableism is a set of beliefs, stereotypes, and practices aimed at people living with disabilities and is based in the belief or desire to "cure" or "fix" a person's disability to make them "normal". Such a mentality portrays individuals with disabilities as being defined by their disability, and inherently less than or inferior to those without disabilities[169],[170]. Structural ableism in healthcare refers to a system of historical and contemporary policies, institutions, and societal norms and practices that devalue and disadvantage people living with a disability. These systems privilege people who are represented as able in body and mind and result in different access to healthcare resources and worsened health outcomes[171]. The ableist mentality and systems of structural ableism present a point of view and interpretation of the world from a perspective that is inherently blind to the diversity of ways of interacting with the world and society.

Number 2 Patient-Related and Person-Centered Disability Policy

The personal, financial, and societal costs of health disparities have long been recognized[172],[173]. While some progress has been achieved in reducing disparities by race, ethnicity, sex, and gender, disability status continues to be associated with poorer health outcomes[174]. Evidence suggests that ableism, defined as prejudice and discrimination aimed at disabled people, often with the implicit goal of "curing" their disability, is a key driver of these disparate health

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166 Wickenden M. Disability and other identities?-how do they intersect? Front Rehabil Sci. 2023 Aug 10;4:1200386. doi: 10.3389/fresc.2023.1200386. PMID: 37637932; PMCID: PMC10449449.

167 Dorsey Holliman B, Stransky M, Dieujuste N, Morris M. Disability doesn't discriminate: health inequities at the intersection of race and disability. Front Rehabil Sci. 2023 Jul 6;4:1075775. doi: 10.3389/fresc.2023.1075775. PMID: 37484601; PMCID: PMC10357509.

168 Horner-Johnson, W. (2021). Disability, Intersectionality, and Inequity: Life at the Margins. In: Lollar, D.J., Horner-Johnson, W., Froehlich-Grobe, K. (eds) Public Health Perspectives on Disability. Springer, New York, NY. https://doi-org.proxy.westernu.edu/10.1007/978-1-0716-0888-3_4

169 Smith L. #Ableism. Center for Disability Rights. Published 2023. https://cdrnys.org/blog/uncategorized/ableism/

170 6.Dunn D. Understanding ableism and negative reactions to disability. American Psychological Association. Published December 15, 2021. https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/ableism-negative-reactions-disability

171 Structural ableism in public health and healthcare: a definition and conceptual framework Lundberg, Dielle J. et al. The Lancet Regional Health – Americas, Volume 30, 100650

172 National Healthcare Quality and Disparities Report. (2023). Retrieved: February 16, 2025. Available from: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr23/index.html

173 Artiga S, Orgera K & Pham O. (2020). Disparities in health and healthcare: Five key questions and answers. Retrieved: February 16, 2025. Available from: http://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers

174 Krahn GL, Walker DK, Correa-De-Araujo R. Persons with disabilities as an unrecognized health disparity population. Am J Public Health. 2015;105 Suppl 2(Suppl 2):S198-S206. doi:10.2105/AJPH.2014.302182

outcomes both in society at large and in medicine[175],[176],[177],[178],[179],[180]. Despite hard-won rights, largely codified in the Americans with Disabilities Act (ADA), people with disabilities continue to face disproportionate risk of harm when compared to those without disabilities, including higher rates of sexual victimization, greater threat from eugenics, and poorer social determinants of health such as income and housing insecurity[181],[182],[183],[184]. Bioethicists have recently acknowledged that both their field and the medical profession have failed to properly uphold disability rights and that drastic, rapid reform is paramount[185].

Multiple factors contribute to disparities in healthcare for people with disabilities[186]. People with disabilities face numerous physical, communication, knowledge, structural, and attitudinal barriers to care[187]. Most physicians do not use accessible equipment for routine care of patients with mobility limitations[188]. Inaccessibility to receiving care contributes to increasing health disparities for patients with disabilities; therefore, accessibility must be a priority for healthcare institutions, starting with adherence to ADA guidelines. Beyond physical accessibility, patients with disabilities must be granted autonomy and dignity in their healthcare decisions. Surrogate decision makers should only be used as a last resort. Guidelines and policies on promoting autonomy and decision-making for patients with disabilities have been published by many prominent organizations, including the American Medical Association[189], American Association

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on Intellectual and Developmental Disabilities[190], American Academy of Pediatrics[191], and Disability Rights Oregon[192]. Health professionals, including clinicians, public health professionals, and researchers should collaborate with people with disabilities on identifying and overcoming gaps in care.

Improving patient care and health outcomes also requires equipping the current and future healthcare workforce with updated and accurate knowledge about disability health disparities with active involvement of those with lived experiences. Inadequate training causes clinicians to lack confidence in providing care: 36% of physicians reported having little to no knowledge of about their legal responsibilities under the ADA[193] and only 41% of physicians feel that they have the ability to provide equal quality care to patients with disabilities [194]. In addition, biases within healthcare contribute to disparities. A recent study found that the majority of physicians had implicit biases against people with disabilities, despite self-reporting as unbiased[195]. This emphasizes the need for curricula that centers on recognizing and reducing biases. Many physicians also conceptualize disability as primarily medically-focused, ignoring the contributing social factors, further indicating the need for education that builds disability cultural humility[196]. Importantly, the contribution of implicit bias on healthcare disparities can decrease when physicians acknowledge the presence of bias and intentionally practice strategies to combat it, such as perspective-taking (i.e. consciously envisioning another person's viewpoint) and individuation (i.e. focusing on specific information about an individual rather than their social category)[197]. There has been extensive research looking into educational gaps and recommendations for improving curricula on disability healthcare[198],[199],[200],[201]. Still, most medical schools have limited opportunities for in-depth education or meaningful engagement with people with disabilities[202]. Updating curricula to emphasize unbiased, culturally informed, patient-

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centered care has strong potential to improve outcomes, reduce disparities, and strengthen trust in the patient-clinician relationship.

Government also plays a critical role in improving healthcare for and minimizing health disparities among people with disabilities. One of the most direct mechanisms is through insurance-related legislation and policy. The Affordable Care Act (ACA), and resultant Medicaid expansions in some states, including Oregon, have allowed nonelderly adults with disabilities who lack supplemental security income (SSI) to obtain otherwise inaccessible insurance coverage[203]. As of early 2025, Medicaid is the primary source of health and long-term care insurance for one in three Americans with a disability, meaning any reduction in Medicaid access would disproportionately harm people with disabilities[204]. Expanded insurance coverage improves access to ongoing disability care services as well as recommended preventative care, which can often stymie the development of additional disabilities or complications[205],[206].

Policies that protect public health, such as preventing mask bans (at least in healthcare settings) and actively combatting anti-vaccine sentiment are also critical. Both masks and vaccines reduce the risk of developing disabilities (e.g. long COVID) and protect people who are more vulnerable to infectious diseases complications due to their existing disability[207],[208],[209],[210]. Other important policies include promoting community integration for people with disabilities, such as minimizing institutionalization, improving access to education, and increasing suitable employment opportunities. Such government actions would not only promote well-being for people with disabilities directly but also combat long-standing systemic barriers and biases that can socially isolate those with disabilities[211],[212],[213],[214]. Thus, to reduce disparities, expand autonomy, and improve health outcomes for people with disabilities, government policy must

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expand access to comprehensive insurance coverage, counter mask bans and anti-vaccine rhetoric, and promote community integration for disabled people wherever possible.

These policy recommendations allow the OMA to advance healthcare and equity for patients with disabilities by decreasing disparities, upgrading education for current and future clinicians, and advocating for government action.

Number 3 Clinician and Learner Related Disability Policy

Principle 1 - Protections for Students and Trainees with Disabilities

The OMA recognizes that increasing diversity among clinicians to reflect the diverse patient populations they care for leads to improved patient care and outcomes. While 26.8% of people in the United States reported having a disability in 2019, only 3.1% of physicians and 4.6% of medical students reported having a disability[215],[216],[217]. No data currently exists on the percentage of Physician Associates (PA) or PA students with disabilities, and there is limited data on disabilities in graduate medical education (GME) programs. Given this discrepancy, it is important to evaluate the barriers that limit the number of learners with disabilities who are entering medical and PA schools.

Although 93.3% of schools surveyed reported providing disability accommodations, cultural and structural barriers continue to make it difficult for students with disabilities to access medical education in the first place[218]. Technical standards for medical schools vary widely and often have vague "organic" standards that emphasize deficits/limitations rather than abilities. Additionally, only one-third of schools surveyed used language that expressed a clear willingness to provide accommodations for students[219]. It is recommended that technical standards shift to a "functional" model, where the skills a student must master are clearly defined and can be achieved with or without accommodations and assistive technology[220].

Of GME programs with publicly available policies, only 68% contained a statement about disability that was in accordance with Accreditation Council for Graduate Medical Education

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(ACGME) requirements[221]. When prospective students struggle to find information on technical standards and accommodations for medical school, PA programs, and GME programs, they may be discouraged from applying to these programs or seeking necessary accommodations while at the program. Additionally, although the Association of American Medical Colleges (AAMC) recommends a confidential and qualified point person for disability services, over half of the 32 institutions surveyed required residents to disclose a disability directly to the program director[222]. This practice may discourage residents from disclosing disabilities due to fear of experiencing bias, including losing an offer. It may also limit access to accommodations if the program director lacks familiarity with or willingness to implement ADA requirements and disability resources. Both the ADA and several American Medical Association (AMA) policies support the above protections for medical and PA students, as well as residents[223],[224],[225].

Principle 2 - Protections for Clinicians with Disabilities

While the ADA prohibits discrimination based on disability in employment, the culture of medicine and misconceptions about disabilities can lead to discrimination and barriers in obtaining accommodations. A misconception some cite is that patient safety will be compromised if accommodations are provided. However, the AMA emphasizes that patient safety remains paramount and affirms that with reasonable accommodations (as defined by the ADA), clinicians with vision, hearing, mobility, or mental health disabilities can provide safe and effective care[226].

Due to fear of reprisal, clinicians may be hesitant to disclose their disability or request accommodations, which may be especially challenging for those who acquire a disability mid-career[227]. State licensing boards play a vital role in ensuring clinicians practice medicine safely; however, it is essential that they adhere to ADA requirements, particularly the restriction against inquiring about physical or mental health conditions unless those conditions directly affect professional competence[228]. A study on PA licensing found that only 18 of 47 respondents, which included 46 states and Washington D.C., complied with ADA requirements in evaluating

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both initial and renewal licensing applications[229]. As a result, 35% of PAs surveyed expressed reluctance to seek mental health care due to concern of licensure repercussions[230].

When it comes to concerns over the cost of providing reasonable accommodations, research shows that 58% of accommodations have no cost, while the rest typically cost around $500, with tax incentives existing to assist the employer in covering these costs. As stated by the ADA, businesses with 15 or more employees are required to provide reasonable accommodations unless doing so would impose an "undue hardship" [231]. Additionally, under Oregon's state anti-discrimination laws related to employment that is more protective than federal law, businesses with 6 or more employees are required to provide reasonable accommodations[232]. Beyond legal compliance with state and federal anti-discrimination laws like the ADA, creating accessible learning and work environments benefits both clinicians as well as their patients with disabilities. For example, height-adjustable exam tables designed for clinicians who use wheelchairs can also improve accessibility for wheelchair-using patients[233]. Furthermore, studies suggest that physicians with disabilities bring valuable lived experiences that improve cultural humility and patient-centered care, particularly for patients with disabilities[234].

Thus, as supported by AMA and ADA policy, it is crucial to ensure that protections and accommodations for clinicians with disabilities are clearly defined and upheld[235],[236].

Principle 3 - Promoting Accessibility and Inclusion in Professional Spaces

Ensuring that clinicians and students with disabilities have equitable access to professional opportunities is essential for fostering an inclusive and diverse medical community. Barriers to participation in conferences, continuing medical education (CME), and professional events can prevent clinicians with disabilities from accessing the same learning opportunities, career advancement, and networking experiences as their peers. As supported by the AMA, hospitals and educational institutions should prioritize making all facilities fully accessible to clinicians with disabilities[237]. It is currently challenging to quantify the impact these barriers may pose for

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clinicians with disabilities as minimal research on this subject exists. Thus, it is recommended that future studies explore the barriers, effectiveness of accommodations, and outcomes of clinicians with disabilities[238].

APPENDIX AC

APPENDIX AC: SUPPORT FOR TENANTS RIGHTS: RENT FORBEARANCE DURING HOSPITALIZATION

Existing OMA policy is as follows:

The OMA recognizes that a safe, permanent, and affordable home is needed for individuals to appropriately address medical needs, mental health concerns, or substance addiction. The OMA will work with stakeholders to support state policies, legislation, and investments that promote the development of affordable housing that incorporates supportive health services to help Oregonians who experience housing instability and high medical needs to achieve optimal health outcomes.

While renters have new legal rights that provide protections from evictions for late payments if they are able to pay the overdue rent prior to a court hearing, there are no protections for vulnerable patients from experiencing late payment charges when extenuating circumstances arise such as hospitalization.

For the most vulnerable and socially isolated patients who have no local support network and make rent payments via mechanisms that require in person drop-off (check, cash, or money order), being admitted to the hospital represents a situation where the pursuits of physical health and wellbeing are a barrier to ensuring timely rental payment and avoidance of further financial hardship. Being hospitalized represents an acute physical and/or mental situation that can limit a person's ability to perform usual Activities of Daily living and Instrumental Activities of Daily living including paying rent.

Health system infrastructure and support systems to help patients experiencing hardship [due to hospitalization] make payments that require physical drop-off of rent payment are variable by institution and often limited or non-existent, thus patients must choose to leave the hospital prematurely or potentially incur late-payment fees and/or negative impacts to credit reporting agencies.

According to Healthy People 2020, housing instability has negative impacts on physical health. Access to housing is important to help obtain optimal health outcomes[239].

Taking into consideration discussions around eviction, the policy committee supported the original resolution regarding housing instability that many Oregonians face. The committee, however, removed "eviction" from the original resolution following discussions and concerns from both the board and the policy committee that eviction was outside the scope of the OMA.

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APPENDIX AD

APPENDIX AD: PROVIDER TAX

Medicaid Currently

According to KFF, the Medicaid/CHIP program covers nearly 80 million. KFF's figures from March 2025, show 1.3 million covered in Oregon[240].

Existing OMA Policy

The OMA's current policy on Provider Taxes with regard to Medicaid was adopted by the House of Delegates in 2003. This policy, revised by the Board of Trustees in October 2013, called for the Opposition of Provider Taxes to cover the medically needy.[241]

> *Opposition to Provider Tax to Cover Medically Needy: OMA opposes the concept of any form of a provider tax on physicians and other providers of health care to fund in whole or in part that societal responsibility, but rather such funding be derived from a broad-based source of revenue from the public.*

The Oregon Medical Association (OMA) opposes direct taxes on physicians, physician associates, and other individual health care providers as a way to fund government health care programs. While the OMA recognizes that provider taxes on hospitals, managed care organizations (MCOs), and other institutional providers—when negotiated and supported by those entities—have become a key tool for drawing down federal matching Medicaid funds, and that Oregon's Medicaid system relies heavily on broad-based, uniform provider assessments to fund coverage for vulnerable populations, the OMA maintains that individual providers should not be expected to shoulder this financial burden.

The OMA is particularly concerned that physician practices - especially those that are independent or located in rural areas - are already financially vulnerable and should not be further strained by direct or pass-through taxes. These concerns have intensified with the passage of H.R. 1, which includes provisions that threaten to cut federal funding for Medicaid and restrict the use of provider taxes to draw down federal matching funds. If enacted, these changes could shift additional financial responsibility onto providers, jeopardizing access to care and undermining the stability of Oregon's health care delivery system.

The recommendations from the Policy Committee serve in part to update and revise existing OMA policy and affirm the OMA's stance on provider taxes.

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APPENDIX AE

APPENDIX AE: PROTECTION OF HEALTHCARE AND HUMANITARIAN AID PERSONNEL IN CONFLICT ZONES

COMMENTS:

In recent years, there has been a dramatic escalation of violence against healthcare personnel and humanitarian aid workers around the world. According to UN and NGO reports, 2024 was the deadliest year on record, with 383 humanitarian workers killed, nearly half in Gaza alone. Similar attacks have been documented in Sudan, Myanmar, Ukraine, and Syria, where hospitals and clinics have been bombed, medical convoys obstructed, and health care providers detained or executed. (UN News, 2025; PBS, 2024).

The deliberate targeting and obstruction of medical care—is referred to by some ethicists and human rights observers as **"medicide."** Attacks on hospitals, forced displacement of populations, and the deliberate prevention of medical supply delivery have become systematic tactics in modern conflicts, in direct violation of International Humanitarian Law (BMJ, 2023; PHR, 2024; HRW, 2025). These actions have resulted in catastrophic health outcomes for civilian populations and have undermined the safety and neutrality of medical and humanitarian missions globally.

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- The Atlantic, 2025: Sudan's humanitarian crisis
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- BMJ, 2023: Attacks on Ukraine's health system
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