

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinion was presented by Ronald J. Clearfield, MD, Chair.

1. COLLABORATIVE CARE

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: FILED

See Opinion E-10.8

At the 2016 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted the recommendation of Council on Ethical and Judicial Affairs Report 1-I-16, “Collaborative Care.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-10.8 Collaborative Care

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams, physicians individually should:

- (a) Model ethical leadership by:
 - (i) understanding the range of their own and other team members’ skills and expertise and roles in the patient’s care;
 - (ii) clearly articulating individual responsibilities and accountability;
 - (iii) encouraging insights from other members and being open to adopting them; and
 - (iv) mastering broad teamwork skills.
- (b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.
- (c) Help clarify expectations to support systematic, transparent decision making.
- (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member’s opinion is heard and considered and team members share accountability for decisions and outcomes.
- (e) Communicate appropriately with the patient and family and respect their unique relationship as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

- (f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
- (g) Encourage their institutions to identify and constructively address barriers to effective collaboration.
- (h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care. (II, V, VIII)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–7, were presented by Ronald J. Clearfield, MD, Chair.

1. AMENDMENT TO E-2.3.2, “PROFESSIONALISM IN SOCIAL MEDIA”

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED**

See Opinion E.2.3.3

At the 2016 Annual Meeting, Policy D-478.969, “Social Media Trends and the Medical Profession,” was adopted, calling on the Council on Ethical and Judicial Affairs (CEJA) to reconsider Ethical Opinion E-2.3.2, “Professionalism in the Use of Social Media.” (This Opinion was previously E-9.124.)

The social media landscape has evolved since the Opinion’s writing in 2010 and that there is now potential for improving patient education and supporting professional advocacy with ethically appropriate social media uses.

Opinion E-2.3.2 addresses ethical issues surrounding physician uses of social media and other online tools. The Opinion stresses the importance of patient privacy and confidentiality when posting content online, separating personal and professional accounts, maintaining appropriate physician-patient boundaries online, and calling attention to or reporting unprofessional online content or behavior of other colleagues.

At close examination, D-478.969 and the Opinion address two different issues. Opinion E-2.3.2 generally speaks to the ethical behavior that a physician should adhere to when engaging in non-clinical, personal uses of social media. This includes maintaining adequate privacy settings on social media profiles, separating personal and professional accounts, using caution when “befriending” patients on personal networks, and reporting colleagues’ unprofessional postings. In this way, the Opinion addresses situations where a physician uses social media for personal purposes and how to ensure appropriate physician-patient boundaries are maintained in that dimension.

There are other uses of social media that have also appeared over the years since the Opinion’s writing. These include encrypted messaging services that allow patients and physicians to communicate about clinical care such as WhatsApp™, Telegram™, and TigerText™. While these applications and their ethical concerns are certainly emerging technologies, they are best covered by Opinion E-2.3.1, “Electronic Communication with Patients.”

Policy D-478.969 directs CEJA to examine how physicians may ethically use social media for educational and advocacy purposes. Education and advocacy can be viewed as activities separate from a physician’s personal life. While not directly related to patient care (e.g., telemedicine), education and advocacy content posted online would still not fall under the scope of Opinion E-2.3.2 as it is currently written. Examples include tweets or blogs about healthcare policy reforms, patient care advocacy, or discussing clinical case studies with other colleagues. Physicians who use social media for advocacy purposes can find guidance under Opinion E-1.2.12, “Ethical Practice in Telemedicine.” However, expanding the scope of the Opinion E-2.3.2 can serve to capture other scenarios that the Directive seeks to address.

USES OF SOCIAL MEDIA FOR EDUCATION OR ADVOCACY

It is important to note that while there has been an expansion of the various ways in which social media is used, the same ethical considerations continue to apply. Photo-sharing applications (such as Figure1™), 1 discussion boards (such as the medicine subreddit or meddit) and other various platforms have become popular among physicians looking to engage other physicians in shop-talk. Through these platforms, physician users can upload photos of rare or complex cases they encounter to help educate other physicians or to gather additional information that may be helpful in the diagnosis or treatment of that patient.

Some applications, such as Figure1™, only allow deidentified photos to be posted. Users must remove identifying information before posting (faces, tattoos, etc.) and all photos undergo additional verification before being posted.

Patients must also consent to their photo being shared. Additionally, users of the application are asked for their occupational information and only healthcare professionals can comment or upload photos. Forums like Reddit or Twitter have no such safeguards. It is solely up to the physician to comply with ethical guidelines and not post identifying information or other inappropriate information online.

The benefits for education and patient treatment are apparent with these applications. The collective knowledge of thousands of physicians is at one's fingertips, and anecdotal evidence shows that physicians do benefit from using these platforms. The net benefit of using these platforms does not temper any responsibility to abide by the ethical guidance already outlined in Opinion E-2.3.2.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Opinion E-2.3.2, "Professionalism in the Use of Social Media," be amended by addition as follows and that the remainder of this report be filed:

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

- (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- (b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.
- (c) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
- (d) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.
- (e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
- (f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
- (g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)

2. COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: REFERRED

The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians' technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council's purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" and as "developmental, impermanent, and context dependent" [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower legal definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

SELF-ASSESSMENT & ITS LIMITATIONS

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians' "individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles" [11].

Self-assessment has thus become "integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students" [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party

evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers' performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5, 12, 17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors' perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain the competence they need to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, “The road to self-knowledge may run through other people” [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20]. They may also question the accuracy and credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued by both those being assessed and those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews (“360° reviews”), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and “provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies” [22].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians' thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes “fast” from “slow” thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [25]. Some scholars take expertise to involve “fast” processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [23]. Others argue that expertise consists in using “slow,” effortful, analytic processes to address problems [23]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment (“situational awareness”) and can determine when to shift to effortful processes [23].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one's] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [23], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to transition

into a more effortful state [24]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [23].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education, training, and experiences that provide tools with which to shape their clinical reasoning. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [27], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [27]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [25, 27, 29].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [30]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [30]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [27]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement

[29]. Overconfidence in one's abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one's limits [27, 29].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [27]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one's weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that "should be accepted as forever outside one's scope of competent practice" [31]. Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence" and to "set appropriately challenging learning goals" that push the boundaries of the physician's knowledge [31].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [32]. The ability to monitor oneself in the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to "slow down" during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [24].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [33, 34], by disrupting memory processes, particularly the "prospective memory"—i.e., "a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so"—important for resuming interrupted tasks [34, 35]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [36].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one's knowledge and responding accordingly [32]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians' self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for "mindful" practice, is an essential marker of competence broadly understood:

Safe practice in a health professional's day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient This decision making in context is importantly different from being able to accurately rate one's own strengths and weaknesses in an acontextual manner. ... Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing 'reflection-in-practice,' addressing emergent problems and continuously monitoring one's ability to effectively solve the current problem [31].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one's practice is that, unlike standardized examinations, they are drawn from one's actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one's communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician's practice lifetime [37]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [37].

“Mindful practice,” that is, being fully present in everyday experience and aware of one's own mental processes (including those that cloud decision making) [38], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [38].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values” [38].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The profession of medicine promises that throughout their careers practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses. Medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills.

However, the ethical responsibility of competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:

- (a) Exercise continuous self-awareness and self-observation;
- (b) Recognize that different points of transition in professional life can make different demands on competence;
- (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations;
- (d) Seek feedback from peers and others;
- (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.

Medicine as a profession should continue to refine mechanisms to meaningfully assess physician competence, including:

- (f) Developing appropriate ways to assess knowledge and skills across the professional lifecycle;
- (g) Providing meaningful opportunity for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment;
- (h) Supporting efforts to develop more and better techniques to address gaps in knowledge, skills, and self-awareness.

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3. ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: REFERRED

Directive D-140.957, “Ethical Physician Conduct in the Media,” adopted at the 2015 HOD Annual Meeting, calls for a report on the professional ethical obligations of physicians in the media. The following analysis by the Council on Ethical and Judicial Affairs (CEJA) addresses ethics concerns in this area and offers guidance for physicians who participate in the media.

PHYSICIANS IN THE PUBLIC SPHERE

Physicians’ knowledge is not confined to the clinical setting. Physicians have well-recognized responsibilities to use their knowledge and skills for the benefit of the community as a whole, whether it is by assisting a state health agency in identifying and tracing infectious disease during an epidemic, advocating for improved health care resources to lessen health disparities, or promoting healthful behaviors to help improve the health of communities [1]. Stepping into the media environment can serve as an extension of this public function.

However, the expectations held of physicians as members of the medical profession and of persons in the media are not always compatible. Participation in the media can have unintended consequences for the physician and the medical profession. Information in the public sphere can be sensationalized, misrepresented, or patently falsified, which can have potentially serious consequences if the benefits and drawbacks of medical advice are not appropriately conveyed [2]. Furthermore, physician recommendations may not always reflect the standard of care [3, 4].

A CONTINUUM OF ROLES

Physicians can engage the media in a number of roles. For example, they can serve as conveyors of information or advocates on behalf of public agencies or institutions; as expert consultants on medical science and practice; as commentators on health-related issues of interest to the public; or as journalists covering medicine-related stories. Imagine the following:

Dr. A is head of a health care agency in the federal government. A physician with two decades of public service experience, she is directly responsible for guiding the legislative goals of the agency and is supported by a staff of thousands of federal employees. Dr. A often gives statements to the press about matters under the agency’s jurisdiction, and has, from time to time, participated in press conferences to speak on urgent matters of public health or to make statements intended to garner greater legislative attention and support.

Dr. B works at an academic medical center. He is frequently approached by media outlets to comment on recent breakthroughs in medicine or topical issues in medicine and public health that are making their way through the news cycle. Dr. B also regularly contributes opinion pieces about medicine and health care policy to news outlets.

Dr. C is a physician whose work has been lauded by practitioners, academics, and celebrities alike. Recently, she has launched a daytime television program in which she discusses popular subjects related to medicine, public health, and a general assortment of topics regarding health and well-being. Dr. C maintains a practice where she sees patients, but the majority of her time is now spent producing and appearing on her television show.

As a public official, Dr. A uses the media to further a political agenda regarding the health and well-being of the American public, an agenda she has been tasked with upholding and protecting. For her, the media is a vehicle to address the needs and concerns of the public, and to keep the policy goals of her agency at the forefront of awareness among government and private actors integral to the provision of medical care.

Dr. B is first and foremost an academic physician whose interactions with the media serve a more consultative function. He generally offers his insight only when approached by the media, although he may occasionally use his

training and experience proactively to shed light on topics when he feels the public may derive some educational benefit.

In contrast, Dr. C holds herself out to a national audience as a commentator on any number of subjects falling under the general categories of medicine, health, and wellness—topics that are at least in part developed by producers and pitched for their ability to boost ratings and increase viewership. Her audience may or may not know the specifics of her training and experience, although she uses her medical degree as a symbol of authority and credibility. Moreover, as a media celebrity, the recommendations she makes on air may be especially persuasive [4].

Whatever role physicians adopt when they participate in the media is very different from that of a clinical practitioner interacting with individual patients. Whether the medium is print, digital, or social, physicians who take part in the media marketplace engage in what is fundamentally a unidirectional relationship with the members of a vast audience who may regard themselves as patients, but whom the physician will never encounter in person. When a video clip ends or a reporter stops asking questions, the contact media physicians have with the audience ends. The hundreds, if not millions, of individuals who have watched, listened, or read have no opportunity to provide details about their unique medical histories, probe for more guidance about a treatment that was discussed, or report back to the physician about what effect, if any, the physician's advice has had.

FIDELITY, TRUST, AND DIVIDED LOYALTIES

For physicians in the media, then, navigating successfully among the potentially overlapping roles of clinician, expert consultant, journalist, or (for some) media personality poses challenges. Being clear about what role(s) they are playing at any given time is crucial [3]. So is being aware of how media content they create or the media presence they have blurs the lines of medicine, journalism, and entertainment [3, 5].

For a physician who pursues a distinct career as a singer, a dancer, or a cook on the line in a restaurant kitchen, the new role is entirely different than that of a physician [6]. But when a media career involves depending on the inherent authority of their MD or DO degree rather than their training and skills, physicians in the media are taking advantage of the credibility and prestige bestowed by the public and the media on members of the medical profession [6, 7]. It may never occur to a cancer patient watching a physician on television that “someone highly credentialed might mix critical medical advice with a touch of ‘shock and awe’” even when such behavior might be condemned by other physicians and the medical profession as a whole [7].

Media entities themselves can have diverging interests and goals—winning a Pulitzer or an Emmy for excellence may compete with attracting advertising dollars, viewership, and ratings. Where the latter are the hallmarks of success, the qualifications of physicians who are media personalities, and the quality of the information they are disseminating, can be secondary for producers and audiences [6]. When there is temptation, or pressure, to attract an audience, it can be challenging for physicians to navigate the overlapping roles of health care professional and media personality, and to hold steady to the norms and values of medicine [7].

Trustworthiness and Authoritativeness

By using their medical expertise to reach out to an audience that is local, national, or even global in scale, physicians in the media carry with them heightened expectations as trusted resources, advisors, and representatives of the medical profession. Thus, like physicians in other roles that do not involve directly providing care for patients in clinical settings, physicians in the media should be expected to uphold the values and norms of medicine as a priority [8].

With respect to the recommendations or clinical perspectives a physician contributes to a media forum, such information must be acquired through practical clinical experience or supported by rigorous scientific research that has been carefully vetted within the peer-reviewed literature and presented accurately in the appropriate context [9, 10]. Physicians should likewise be transparent about the limitations of knowledge or experience in a given area.

A message that is inaccurate, questionable, or false, may still be perceived as authoritative because it comes from a physician [2, 7]. Efforts to correct or recant misinformation from the public forum may prove futile. One contemporary example of this is the still pervasive but false public perception that childhood vaccines are linked to autism, despite the fact that this perception rests on a long-since discredited physician's publication and there is

overwhelming scientific consensus that no such relationship exists [11]. Material that is of poor quality and that does not meet expected standards of scientific rigor can mislead individuals who do not question the content of the message, while the promotion of such subpar work can erode the public's trust in the larger medical community [7, 12].

Maintaining Privacy in the Public Eye

Physicians working in the media must be cognizant of their work's impact on patient anonymity, the process of patient consent (concerns of inadvertent coercion), and the potential to exploit patients. They must also make decisions about whether they will present the outcome of a patient case as a fictional representation or as a story of true events [2, 13]. While journalism requires strict adherence to the facts and details of a story, physicians asked to recount a procedure or speak to media about a particular case have a responsibility to obscure or alter details that would reveal a patient's identity unless the patient freely gave informed consent [13]. Physicians must also remain sensitive to how a story will affect patients under their care, and avoid situations where breaches of privacy and confidentiality may occur [13, 14, 15]. In the media, physicians may at times need to emulate storytellers rather than journalists [13].

Physicians must exercise caution when they are asked to publicly diagnose celebrities, politicians, or private individuals currently caught in the media's gaze. Physicians in the media must draw a careful line between using the media to educate the public versus providing a professional opinion when asked to comment on the physical or mental status of a public figure or someone else the physician has not had the opportunity to personally examine [3]. While a sound professional medical opinion reflects a thorough examination of a patient, the clinical history, and all relevant information under the protection of confidentiality, none of this occurs when physicians make casual observations about people [3]. There is a "critical distinction . . . between offering general information about a condition as it pertains to a public figure and rendering a professional opinion about an individual, involving a specific diagnosis, prognosis, or both" [3].

Moreover, physicians may be enticed into offering professional opinion that is outside their individual area of expertise. Physicians who offer expert testimony in court are expected to testify "only in areas in which they have appropriate training and recent, substantive experience and knowledge" [16]. The same expectations should apply to physicians who offer public commentary on health-related matters.

CONFLICTS AND DISCLOSURES

Competing interests are a fact of life for everyone, not only physicians in the media [17]. But as individuals in positions of public trust, media physicians should be especially sensitive to possible conflicts of interest. Even when there is no actual conflict, the appearance of influence or bias can compromise trust in the physician and the broader profession, with downstream consequences for patients and the public.

Taking steps to ensure transparency, independence, and accountability allows media consumers to make informed judgments about the comments or recommendations offered by physicians who are active in the media. Disclosing conflicts of interest is an essential first step [18, 19, 20]. Direct, substantial financial relationships that may influence a physician's judgment, such as research funding, remuneration for advisory services or speaking engagements, or equity interests in featured products or services, should always be disclosed.

Nonfinancial relationships can also affect judgment and should be disclosed; for example, when a media physician has fiduciary responsibilities to a commercial entity that has an interest in the subject matter. Personal, political, ideological, or intellectual interests can also influence professional judgment in particular situations and media physicians should be prepared to disclose such interests [17, 21, 22].

Disclosure alone is not sufficient, however, and may have the perverse effect of inspiring false confidence on the part of media consumers and even discourage the media physician from rigorously ensuring that he or she is offering objective, unbiased information [23]. In some circumstances, the threat of actual or perceived conflicts of interest may be so great that the only way forward is for the physician to avoid the potential situation altogether.

Instituting measures to promote independent content is a further important step. For example, editorial review of proposed content and presentation can help identify possible bias or the appearance of bias or catch elements that

media consumers might be expected to misinterpret. Prohibiting physicians who have clear, unresolved competing interests from being media spokespersons on issues that involve those interests can likewise help ensure independence [24]. Making explicit to viewers the measures taken to address and mitigate the influence of conflicts of interest will hold media physicians accountable to their peers and the public for exercising sound professional judgment.

CONCLUSION

As trusted members of the community who regularly communicate with the public about health and wellness, physicians have a responsibility to consider their ethical obligations to their patients, the public, and the medical profession. In an increasingly technologically adept media marketplace where the context and delivery of messages are shaped by any number of social and financial forces, physicians must carefully delineate who they are and how they want to be perceived. Equally important, physicians should give thought to how they want to frame and support their messages, and how those messages should be consumed and utilized.

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative.

Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other healthcare professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:

- (a) Always remember that they are physicians first and foremost, and must uphold the values and norms of the medical profession.
- (b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.
- (c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.
- (d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:
 - (i) accurate
 - (ii) inclusive of known risks and benefits
 - (iii) based on valid scientific evidence and insight gained from professional experience
- (e) Confine their medical advice to their primary area(s) of expertise, and clearly distinguish the limits of their medical knowledge where appropriate.
- (f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.
- (g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.

- (h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts.

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4. CEJA'S SUNSET REVIEW OF 2007 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
AS EDITORIALY CORRECTED BY CEJA
REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- Each year the House policies that are subject to review under the policy sunset mechanism are identified.
- Policies are assigned to appropriate Councils for review.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
- A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

2007 POLICIES

In this report, the Council on Ethical and Judicial Affairs presents its recommendations regarding the disposition of 2007 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies that originate from CEJA Reports and duplicate current opinions issued since June 2007. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. After the corresponding CEJA Opinion is issued, CEJA utilizes its annual sunset report to rescind the duplicative House policy.

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, "Pediatric Decision-Making." It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to

eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council's 2009 sunset report.

The Appendix provides recommended actions and their rationale on House policies from 2007, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

Policy No.	Title	Recommended Action & Rationale
H-20.915	HIV/AIDS Reporting, Confidentiality, and Notification	Retain: Policy remains relevant
H-65.979	Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth Organization	Retain: Policy remains relevant
H-65.983	Nondiscrimination Policy	Retain: Policy remains relevant
H-65.988	Organizations Which Discriminate	Retain: Policy remains relevant
H-140.896	Moratorium on Capital Punishment	Retain: Policy remains relevant
H-140.900	A Declaration of Professional Responsibility	Retain: Policy remains relevant
H-140.978	Financial Incentives to Limit Care – Ethical Implications for HMOs and IPAs	Retain: Policy remains relevant
H-445.996	Public Awareness and Education	Rescind: Policy is outdated and no longer remains relevant.
H-445.998	Proprietary of Professional Public Communications	Retain: Policy remains relevant
H-460.919	Privacy and Confidentiality	Rescind: Policy is outdated and no longer remains relevant.
D-20.991	Ethical and Legal Issues in Responding to Occupational HIV Exposure	Rescind: Recommendation of CEJA Report 4 were adopted following the adoption of this resolution.
D-250.990	Israeli Medical Association	Retain.
D-370.995	Anatomical Gifts	Rescind: Policy is no longer relevant in light of Endorsement of the Uniform Anatomical Gift Act (2006) H-370.968 (reaffirmed 2016).

5. STUDY AID-IN-DYING AS END-OF-LIFE OPTION (RESOLUTION 15-A-16)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Resolution 15-A-16, “Study Aid-in-Dying as End-of-Life Option,” presented by the Oregon Delegation and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) and its Council on Judicial and Ethical Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying.”

Testimony spoke to the fact that many states have proposed or adopted legislation to legalize the practice, introducing a potential conflict for our members in those states. Additional testimony recognized the need for our AMA to respond to this highly relevant and expanding issue that may impact medical practice, looking to the Council on Ethical and Judicial Affairs for guidance.

The question of whether physicians may actively aid death is of extraordinary importance to patients, families, and the medical profession and demands thorough and thoughtful reflection. CEJA has begun reviewing the extensive literature regarding physician aid in dying, along with numerous communications received to date that reflect diverse views. In addition, CEJA invited interested members of the House to participate in an open house session on June 10th to provide further input to help inform its deliberations.

In light of the complex and deeply contested nature of the issues at stake, CEJA believes it is wisest to proceed cautiously and allow ample time for thoughtful reflection in developing its report.

6. RELIGIOUSLY AFFILIATED MEDICAL FACILITIES AND THE IMPACT ON A PHYSICIAN'S ABILITY TO PROVIDE PATIENT CENTERED, SAFE CARE SERVICES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-140.956, "Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services," asks that the American Medical Association (AMA):

conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously-affiliated hospital systems.

The resolution on which this directive is based discussed the conflicts present in decision-making for health care professionals employed by religiously affiliated institutions. Given that the presence of religiously affiliated hospitals continues to grow, caring for more than 1 in 6 patients, the resolution encouraged our AMA to conduct a study of access to care in secular hospitals and religiously affiliated hospitals to include any impact on access to services in the consolidation of systems.

Council on Ethical and Judicial Affairs' (CEJA) deliberations on this topic are ongoing; CEJA therefore intends to submit its final report at the 2017 Interim Meeting.

7. JUDICIAL FUNCTION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: ANNUAL REPORT

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

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

they may be expelled. Updated rules for review of membership can be found at ama-assn.org/rules-review-membership.

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

APPENDIX – CEJA Judicial Function Statistics, April 1, 2016 - March 31, 2017

Physicians Reviewed	<u>SUMMARY OF CEJA ACTIVITIES</u>
4	Determinations of no probable cause
54	Determinations following a plenary hearing
16	Determinations after a finding of probable cause, based only on the written record, after the physician waived their plenary hearing right

Physicians Reviewed	<u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u>
23	No sanction or other type of action
1	Monitoring
14	Probation
12	Revocation
9	Suspension
2	Application denied
9	Censure

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