

## OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinion was presented by Dennis S. Agliano, MD, Chair.

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

*CEJA Opinion; no reference committee hearing.*

#### HOUSE ACTION: FILED

#### INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-A-17, “Amendment to E-2.3.2, Professionalism in Social Media.” 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-2.3.2, Professionalism in Social Media

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 ethics guidance 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)

## REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–4, were presented by Dennis S. Agliano, MD, Chair.

### 1. 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 both by those being assessed and by 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]. Beyond such formal mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

## 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 expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility 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 for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

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## 2. ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED**

*See Policies H-140.836 and D-140.957*

Directive D-140.957 (1), “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 behaviors that 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 their 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.

## RECOMMENDATIONS

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted in lieu of D-140.957(1) 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 health care 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, norms, and integrity 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) commensurate with their medical expertise
  - (iv) based on valid scientific evidence and insight gained from professional experience
- (e) Confine their medical advice to their area(s) of expertise, and should 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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### 3. SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT (DSD) (RESOLUTION 3-A-16)

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

#### HOUSE ACTION: REFERRED

At the 2016 Interim Meeting, the American Medical Association (AMA) House of Delegates referred Board of Trustees Report 7-I-16, “Supporting Autonomy for Patients with Differences of Sex Development (DSD),” responding to Resolution 3-A-16 of the same title introduced by the Medical Student Section, which had previously been referred. Resolution 3 asked:

That our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

Testimony regarding BOT 7-I-16 expressed concern about possible unintended consequences and lack of expert insight into the medical complexities in treating differences of sex development in pediatric patients. The Council on Ethical and Judicial Affairs was asked to prepare a report providing ethics guidance in this area.

#### BACKGROUND

The term “differences of sex development” (DSD), now preferred over “disorders of sex development,” is used to refer to congenital conditions “in which development of chromosomal, gonadal, or anatomic sex is atypical,” broadly encompassing five main groups [1]:

- 46,XX, classical congenital adrenal hyperplasia (CAH);
- 46,XY, a heterogeneous set of conditions that includes abnormal androgen steroidogenesis and 5 $\alpha$  reductase deficiency;
- varieties of sex chromosome mosaicism, such as mixed gonadal dysgenesis (45,X/46,XY DSD);
- ovo-testicular DSD in which patients present with both ovarian and testicular tissues and abnormally differentiated genital structures; and
- “nonhormonal/nonchromosomal” DSD, represented by abnormal genitalia.

The frequency of DSDs varies with etiology [2,3], but overall incidence of DSD is estimated to be one in 5,500 births [4]. Congenital adrenal hyperplasia accounts for approximately 60 percent of all DSDs [3]. Diagnosis of DSD is complex, encompassing family and prenatal history, physical examination (particularly of genital anatomy), and various laboratory tests, including determination of chromosomal sex. Diagnosis may also involve ultrasound or other imaging studies, hormonal stimulation tests (e.g., human chorionic gonadotropin or adrenocorticotropin stimulation), and, in rare cases, laparotomy or laparoscopy [4]. Some 60 percent of affected children are now diagnosed prenatally [4].

DSD include potentially life-threatening developmental anomalies that may require immediate intervention, for example, hypotension resulting from salt-wasting nephropathy, which occurs in 75 percent of infants born with congenital adrenal hyperplasia. DSD also include “cosmetic” abnormalities for which elective interventions to normalize appearance can be undertaken at various stages in the child’s life [3,5].

Early diagnosis is essential to identify and intervene in life-threatening conditions. Historically, treatment for DSD also gave high priority to medically assigning gender in a newborn with ambiguous genitalia under what became known as an “optimal gender policy” intended to “facilitate stable gender identity and appropriate gender role behavior” [5]. This approach recommended early surgery to match genitalia to assigned gender, on the rationale that uncertain gender is distressing for the family, may adversely affect the child’s mental health, and can lead to stigmatization [4,5,6]. This view has been increasingly challenged [5,7]. DSD communities and a growing number of health care professionals have condemned such genital “normalizing,” arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making [5,8,9,10].

In 2006, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) observed that “[m]uch of the clinical challenge intrinsic to pediatric urology rests in the need to discriminate between children at risk for severe long-term complications and requiring intervention and the larger group who are not. The report noted the lack of sufficient data to guide decisions about gender assignment and absence of clear guidelines for clinical practice, particularly in light of concerns about the irreversibility of surgical intervention and possible sensory damage to the genitalia [11]. The NIDDK cited the lack of “systematic outcome data about sexual function in individuals with disorders of sexual differentiation [sic]” and of data “pertaining to the association of sexual function with genital appearance and types of genital surgery.” It concluded that “it is unclear whether gender identity requires gender-consistent genital appearance” and urged prospective studies of gender identity, reproductive function, and quality of life for patients with DSD [11].

A decade later, outcomes data remain limited. A small study carried out in 2011–2012 among medical students in Zurich found that how physicians discussed treatment for a child with DSD influenced the choice for or against surgery [12]. Participants watched brief counseling videos that described DSD either as a condition that is static, has an inherent psychosocial component, and requires treatment, and for which predetermined treatment regimens focus on biological function, or as a dynamic disorder characterized by context-dependent impairment for which coping strategies should be fostered, with treatment geared to the individual’s interests and capabilities. Sixty-six percent of participants who viewed the medicalized video said they would choose early surgery for their child, compared to 23 percent of those who viewed the demedicalized video. In a systematic review of follow-up of psychological outcomes of intervention for patients with DSD published in 2015, Brazilian researchers found a lack of prospective long-term evaluations of psychological outcomes of sex assignment surgery [13]. They noted concerns about the quality of published studies, citing variable sample size, inconsistent methodologies, and poorly defined outcome measures.

## NEW PARADIGMS FOR TREATMENT

In addition to the NIDDK report questioning the “optimal gender” policy, in 2006 both the Intersex Society of North America (ISNA) and the International Consensus Conference on Intersex released guidelines on the management of DSD that urged a more conservative approach [1,14]. ISNA guidelines note that gender assignment “is a social and legal process *not requiring medical or surgical intervention*” (original emphasis) [ISNA 2006]. The guidelines recommend delaying elective surgical and hormonal treatments until the patient can participate in decision making and caution that health care professionals must distinguish between offering medically needed treatment to benefit the child and offering treatment to allay parental anxiety. Like the ISNA, the consensus statement of the International Consensus Conference on Intersex recommended deferring elective interventions and similarly urged that care be provided by a multidisciplinary team. In 2016 the Global DSD Update Consortium reviewed developments over the preceding decade, noting particularly the important role that peer support can play in helping parents, and children, make informed decisions about elective treatment [15].

In its 2017 report on the rights of children in biomedicine, the Bioethics Committee of the Council of Europe observed that, based its review of on available scientific evidence, only three interventions meet criteria of being “medically necessary”: “(1) administration of endocrine treatment to prevent fatal salt-loss in some infants, (2) early removal of streak gonads in children with gonadal dysgenesis, and (3) surgery in rare cases to allow exstrophic conditions in which organs protrude from the abdominal wall or impair excretion” [16]. However, these recommendations remain controversial and there is not yet consensus in the medical community. Recent interviews carried out by Human Rights Watch among individuals with DSD examine patient experience and underscore the value of organizing dedicated multidisciplinary care teams [17].

In educational material for parents, the American Academy of Pediatrics likewise stresses multidisciplinary care and notes that, if not medically necessary, “any irreversible procedure can be postponed until the child is old enough to agree to the procedure (e.g., genital surgery)” [18].

## CURRENT AMA POLICY

Current AMA policy does not address treatment for patients with DSD directly. Rather, a limited number of ethics and House policies speak to decisions for minors more broadly, as well as to issues pertaining to gender identity, sexual orientation, transgender health, and discrimination toward sexual minority communities:

- [Opinion 2.2.1](#), “Pediatric Decision Making,” encourages involving minor patients in decision making at a developmentally appropriate level, including decisions that involve life-sustaining interventions, and recommends that physicians work with parents or guardians to simplify complex treatment regimens for children with chronic health conditions.
- [Opinion 2.2.4](#), “Treatment Decisions for Seriously Ill Newborns,” articulates the considerations that must be taken into account when addressing emotionally and ethically challenging cases involving newborns, including: the medical needs of the child; the interests, needs, and resources of the family; available treatment options; and respect for the child’s right to an “open future.” It calls on physicians to inform parents about available therapeutic options and the nature of those options and to discuss the child’s expected prognosis with and without intervention.
- [Opinion 2.2.5](#), “Genetic Testing of Children,” identifies conditions under which physicians may ethically offer genetic testing for minor patients. It observes that testing implicates important concerns about the autonomy and best interests of the minor patient and holds that medical decisions made on behalf of a child should not abrogate the opportunity to choose to know his or her genetic status as an adult.

## DECISIONS FOR PEDIATRIC PATIENTS

Parents (or guardians) are granted the authority to make health care decisions for their minor children when the child lacks the ability to act independently or does not have the capacity to make medical decisions [19]. Parents are deemed to be in a better position than others to understand their child’s unique needs and interests, as well as their family’s, and thus to be able to make appropriate decisions regarding their child’s health care. Historically, the best interest standard has predominated as the appropriate decision-making standard for medical decisions for minors. Current consensus rests on a more nuanced view that encompasses not only the patient’s medical interests, but psychosocial and familial concerns as well [19].

The “harm principle” has been suggested as a further refinement on the decision-making standard, requiring not only that decision makers consider the patient’s best interests, broadly understood, but also that a threshold of harm be identified, below which decisions should not be tolerated [19]. Parents (or guardians) are also recognized to have a responsibility to foster their children’s autonomy and moral growth, a responsibility clinicians share. Providing information in a developmentally appropriate way that respects the minor patient’s cognitive ability, engaging the child in decision making to the extent possible, and seeking the child’s assent to proposed interventions helps to fulfill that responsibility [19].

With respect to DSD specifically, suggested broad principles to guide decisions about elective interventions have been suggested. Proposals emphasize the need to balance leaving future options open [9] and upholding the child’s right to participate in decision making [5] with respect for parents’ wishes and family relationships. Likewise, they concur that decisions for patients with DSD should focus on promoting the well-being of the child and future adult [5], including minimizing physical and psychosocial risks to the child, preserving potential for fertility, and preserving capacity for satisfying sexual relations [9].

In cases of DSD, decisions about a child’s best interests and appropriate interventions involve sensitive issues of sex, gender, and sexuality, and interventions that may be irreversible. Parents are often concerned about the future well-being of their child with regard to self-identity, relationships, and reproductive capacity [8]. Because of these concerns, they may be quick to want to establish sex and gender identity for their child in order to promote “normalcy” and reduce stigmatization. Moreover, when physicians perceive early intervention to be urgently needed or wholly beneficial, they may not fully recognize that there is a decision to be made, or the complexity of that decision for the family and patient.

A 2013 lawsuit, though unsuccessful, raised constitutional issues with respect to early surgical intervention and sex assignment. In 2013, the adoptive parents of a South Carolina child, MC, born with “ovotesticular DSD” filed suit in the US District Court for the District of South Carolina against physicians who had performed feminizing genitoplasty on the child at age 16 months. At the time of surgery, MC was under the legal custody of the South Carolina Department of Social Services, which authorized the intervention. Despite initially being raised as a girl by his adoptive parents, consistent with his surgically assigned sex, MC identified as a boy and at the time the lawsuit was filed was living as a boy. Because of the surgery, MC is now sterile. Although the action was dismissed on



appeal by the US Court of Appeals for the Fourth Circuit (in January 2015) [20], the lower court had denied the defendants' request for dismissal on the grounds that the defendants may have violated MC's constitutional right to procreate [21]. In July 2017, the Medical University of South Carolina denied all claims and liability, but agreed to a settlement with the family [22].

## RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, "Pediatric Decision Making," be amended as follows in lieu of Resolution 3-A-16 and the remainder of this report be filed:

Unlike health care decisions for most adult patients, decisions for pediatric patients usually involve a three-way relationship among the minor patient, the patient's parents (or guardian), and the physician. Although children who are emancipated may consent to care on their own behalf, in general, children below the age of majority are not considered to have the capacity to make health care decisions on their own. Rather, parents or guardians are expected, and authorized, to provide or decline permission for treatment for minor patients. Nonetheless, respect and shared decision making remain important in the context of decisions for minors, ~~and p~~ Physicians have a responsibility to support the child's emerging autonomy and should engage minor patients in making decisions about their own care to the greatest extent possible, ~~including decisions about life sustaining treatment.~~

Decisions made for pediatric patients should seek to foster the well-being of children patients and the adults they will become. Physicians should provide information and other resources to support parents or guardians in making decisions about their child's care and should individualize treatment to promote the child's best interest, ~~which is determined by~~ weighing many factors, including effectiveness of available appropriate medical therapies and the needs and interests of the patient and the family as the source of support and care for the patient.

Parents or guardians must also assess whether the decision made for a minor patient will abrogate a choice the future individual would want to make for him- or herself. Except when immediate treatment is medically necessary to preserve life or avert serious and irreversible harm, physicians should support parents' efforts to make decisions that do not undermine the child's right to an "open future." When there is ~~legitimate inability to reach~~ no consensus in the field about what is in the best interest of the child, the wishes of the parents/guardian should generally receive preference.

For health care decisions involving minor patients, physicians should:

- a) Involve all patients in decision making at a developmentally appropriate level.
- b) Base recommendations for treatment on the likely benefit to the patient, ~~taking into account the effectiveness of treatment, risks of additional suffering with and without treatment, available alternatives, and overall prognosis~~ as indicated by the best available scientific evidence. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify the value to patients of different approaches to care.
- c) For patients capable of assent, truthfully explain the medical condition, its clinical implications, and the treatment plan in a manner that takes into account the child's cognitive and emotional maturity and social circumstances for patients capable of assent.
- d) Provide a supportive environment to promote the well-being of both the patient and the family and encourage parents to discuss their child's health status with the patient. Offer to facilitate the parent-child conversation for reluctant parents.
- e) Recognize that ~~for~~ certain medical conditions, such as those involving HIV/AIDS, ~~or~~ inherited conditions, or developmental anomalies, may involve highly sensitive information. ~~Disclosing the child's health status may also reveal health information about biological relatives, or disrupt relationships within the family, or lead to stigma or discrimination. Physicians should offer education and support to help minimize the psychosocial impact of such conditions for the child and the family.~~

- f) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents in ways to avoid behaviors that put the child or others at risk.
- g) ~~Ensure that w~~When decisions involve life-sustaining interventions, ensure that patients have opportunity to be involved in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardian understand the patient's diagnosis, both with and without treatment. Physicians should discuss with the patient and parents/guardian the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a specified amount of time to determine if it has led to improvement. Confirm that if the intervention has not achieved agreed-on goals it may be withdrawn.
- h) Respect the decisions of the patient and parents/guardian when it is not clear whether a specific intervention promotes the patient's best interests.
- i) Seek consultation with an ethics committee or other institutional resource when:
  - (i) there is a reversible life-threatening condition and the patient (if capable) or parents/guardian refuse treatment the physician believes is clearly in the patient's best interest; or
  - (ii) there is disagreement about what the patient's best interests are. Physicians should turn to the courts to resolve disagreements only as a last resort.
- j) Provide compassionate and humane care to all pediatric patients, including patients who forgo or discontinue life-sustaining interventions.

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#### 4. MERGERS OF SECULAR AND RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

##### HOUSE ACTION: REFERRED

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, 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.

##### RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS

The concept of the hospital as a facility providing inpatient care for the sick originated with the Catholic Church, with the original and enduring dual mission of healing the body and promoting spiritual well-being [1]. The mission of today’s Catholic Health Association remains focused on the needs of those who are “poor, underserved, and most vulnerable” [2]. Although hospitals established by Protestant denominations and Jewish-identified facilities remain important segments of U.S. health care, Catholic facilities predominate among religiously affiliated institutions—U.S. Catholic Health Care is the largest nonprofit care provider in the country [2].

Since the 1990s, mergers between secular and religiously affiliated hospitals and health care institutions have been reshaping the landscape of health care in the United States, for both patients and physicians. Driven by economic considerations and changes in health policy, notably in recent years, emphasis on accountable care organizations and bundled payments [1,3], mergers have enabled facilities in some cases simply to survive and in others to thrive within their communities. Consolidation has enabled hospitals to control a greater share of their local markets and to negotiate effectively with insurers [4].

Religiously affiliated hospitals and facilities benefit from the tax-exempt status of the religious institutions they represent and from other tax subsidies that derive from their mission to serve the poor and provide charitable care [5]. Although the majority of religiously affiliated hospitals remain nonprofit, the number of for-profit hospitals affiliated with religious institutions increased by 22 percent between 2001 and 2016 [6]. Religiously affiliated health care facilities—which encompass clinics, hospitals, and long-term care facilities—are also important employers. According to the Catholic Health Association, as of 2017 member facilities employed more than 500,000 full-time and 200,000 part time staff [2].

In some communities, religiously affiliated health care institutions may be the only providers [6]—as of 2015, 132 of the nation’s approximately 1,300 critical access hospitals were members of U.S. Catholic Health Care [2]. In

some areas, more than 40 percent of short-term, acute care beds are in Catholic facilities [6]. Nationwide, one in every six patients now receives care in a Catholic hospital [2].

### THE DILEMMA OF MERGERS

The consolidation of a religiously affiliated institution with a secular health care facility raises challenges for all stakeholders—the facilities, their communities, their patients, and the physicians and other professionals who provide care. All religiously affiliated institutions seek to remain faithful to their defining mission and values, which can place them in tension with their secular counterparts. Catholic facilities, however, are embroiled in an increasingly public debate about the implications and effects of entering into arrangements with secular institutions as they seek to retain their identity and mission and still survive in the health care marketplace. Thus they offer a window through which to understand the ethical dimension of health care mergers.

As the *Ethical and Religious Directives* that govern care in Catholic health care facilities observe:

New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles (§VI)[7].

From this perspective, in the contemporary health care marketplace Catholic hospitals “are caught in an impossible bind” [1]. Like other hospitals, financial pressures drive them to consolidate with other institutions to become more economically efficient. Yet “competing in the aggressive world of the medical business industry” can put Catholic hospitals’ historical commitment to the poor at risk [1]. At the same time, gaining financial security may risk “imperceptibly compromising their traditional Catholic witness” when compromises are made with respect to *Directives* [1].

From the perspective of those they serve, a merger or consolidation may help guarantee the continued presence of health care in a community, but may also limit the range of services available to patients when the consolidated entity adheres to the *Directives*. Certain treatment choices for care at the end of life, reproductive health care services, and, by some reports, certain services for transgender individuals may all be affected [4, 8, 9]. Limitations on women’s health services have been a focus of concern for obstetricians and gynecologists associated with or employed by religiously affiliated hospitals [10], with reports of conflict over both elective and clinically indicated surgical sterilization [11, 12], and management of miscarriage [13]. Restricted access to services can have a disproportionate impact on poor women, and women in rural areas where religiously affiliated institutions are the only providers of care [14].

From the perspective of physicians and other health care professionals affiliated with or employed by the entity that results, a merger can challenge professional commitments. A merger that results in loss of access to services for the community and requires physicians to follow the religious guidelines embodied in the *Directives* may result in “conflict with prevailing medical standards of care and ethical principles of health care professional” [15]. Physicians and other health care professionals who are not members of the faith tradition may find themselves contractually prohibited from providing care that is otherwise legal and, in their professional judgment, clinically appropriate and ethically permissible under the norms of medical professionalism.

### THE RESPONSIBILITIES OF LEADERSHIP

As challenging as mergers between secular and religiously affiliated health care facilities may be for individual patients and physicians, addressing dilemmas of mission is pre-eminently a responsibility of hospital leadership.

For Catholic facilities merging with secular facilities (or facilities associated with other religious traditions), a touchstone is the principle of cooperation [16, 17]. The principle, it is argued, is a necessity for business relationships in a pluralistic world, providing a way to address the reality that, for the faithful, “it is almost impossible to bring about good without brushing up against or even becoming somewhat involved in the

wrongdoing of others” [16]. The principle of cooperation is understood “as a *limiting principle*, to avoid cooperating in evil” (original emphasis) [17].

The essential goal is to ensure that institutional arrangements allow the facility and its staff to “remain as removed as possible” from violations of the directives and “not [to] contribute anything essential to make possible the wrongdoing’s occurring” [16]—e.g., essential employed staff or equipment for the performance of what under the *Directives* is an immoral procedure [17]. Whether services that would be otherwise prohibited by the *Directives* will or may be available through the merged entity is importantly a function of how caregiving is organized in the resulting composite system. The approval of the diocesan bishop is required for mergers involving facilities subject to his governing authority, and the diocesan bishop has final authority for assessing whether a proposed merger constitutes morally licit cooperation (§VI) [7].

Analogous discussions of the ethics of trusteeship, such as that offered by The Hastings Center, offer secular insight for thinking about the responsibilities of leaders in health care institutions. Trustees of not-for-profit health care organizations “regularly make decisions that affect the lives and well-being of a large number of people who are relatively powerless, relatively vulnerable, and in need of services or assistance” [18]. In light of the mission of such organizations, service on a board of trustees entails fiduciary duties to the organization and responsibility to ensure that the organization realizes the public benefits for which it enjoys tax exempt status.

Trustees are held to principles of fidelity to mission; service to patients, ensuring that the care is high quality and provided “in an effective and ethically appropriate manner”; service to the community the hospital serves, deploying hospital resources “in ways that enhance the health and quality of life” of the community; and institutional stewardship. They have a further responsibility to ensure that when there is conflict over fundamental values and principles, “all points of view are heard and taken seriously, that reasonable compromise is explored, and that consensus has time to form” [18].

The *Principles of Integrated Leadership for Hospitals and Health Care Systems*, developed in collaboration by the American Hospital Association (AHA) and the AMA, address responsibilities of hospital leadership in the context of rapidly evolving models of integrated physician-hospital health care systems [19]. In addition to governance and management structure and leadership development, guidance identifies “cultural adaptation” as a key element for success, observing that:

Culture is the way an organization, institution or integrated health system does business, in a way that is predictable, known to all and consonant with the mission and values of the organization, institution or integrated health system. The creation of a common shared culture that includes an integrated set of values is important to serve as a guide to the entity and will serve as a touch point to help resolve the inevitable conflicts that will arise [19].

The AHA-AMA principles urge integrated health systems to cultivate the characteristics of adaptive institutional culture, including a focus on the health of the entire population served; agreement to a common mission, vision, and values; mutual understanding and respect; and a sense of common ownership of the entity and its reputation [19].

#### INSIGHT FROM THE CODE OF MEDICAL ETHICS

As frontline clinicians, physicians (and other health care professionals) regularly confront the effects on patients’ lives and well-being of the institutional arrangements through which care is delivered. They have a responsibility to advocate for the resources patients need, as well as to be responsible stewards of the resources with which they are entrusted [20]. They must be able to make treatment recommendations in keeping with their best judgment as medical professionals [21]. And they are expected to uphold the ethical norms of medicine, including fidelity to patients and respect for patients as moral agents and decision makers [22].

Existing guidance on exercise of conscience by individual physicians suggests essential responsibilities of leadership in health care as well [22]. These include responsibility to engage in thoughtful consideration of the implications of institutional arrangements—whether arrangements sustain or risk undermining the personal and professional integrity of staff, cause moral distress, or compromise the ability to provide care. Leaders in health care institutions must be mindful that arrangements do not discriminate against or unduly burden individual patients or populations of patients, and of the burden arrangements may place on fellow professionals. And they must accept responsibility

to take steps to ensure that services will be available to meet the needs of the patients and community the institution serves.

## RECOMMENDATIONS

In light of this analysis, the Council on Ethical and Judicial Affairs recommends:

1. That Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services,” be rescinded.
2. That the following be adopted, and the remainder of this report be filed:

The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity.

Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger should:

- (a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the range of services previously offered will continue to be available to the community.
- (b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.
- (c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same range of services remains available in the community.
- (d) Recognize that physicians’ primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.
- (e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with institutions that have consolidated or propose to consolidate should:

- (f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.
- (g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

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