

Reference Committee on Amendments to Constitution and Bylaws

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-17

Subject: Effective Peer Review

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 INTRODUCTION

2
3 At the 2016 Interim Meeting, the House of Delegates adopted Policy D-375.987, “Effective Peer
4 Review.”

5
6 [o]ur AMA study the current environment for effective peer review, on both a federal and state
7 basis, in order to update its current policy to include strategies for promoting effective peer
8 review by physicians and to consider a national strategy for protecting all physicians from
9 retaliation as a result from participating in effective peer review.

10
11 Testimony spoke of the increasing number of physicians who are employed by, or affiliated with,
12 large hospital systems or healthcare organizations, where physicians are concerned that they exert
13 less and less control over their employment and/or practice situations and patient care. As a result,
14 having effective, legitimate peer review processes in place is vital to safeguarding patient care and
15 safety. Further, physicians in the peer review process need protection from retaliation by hospitals
16 and other lay organizations that might be at odds with the role, actions, or decisions taken by those
17 participants. Although the amended language above was originally contained in a resolution, the
18 House of Delegates adopted this language as a “Directive to Take Action.” This report responds to
19 the study requested by AMA Policy D-375.987.

20 21 DISCUSSION

22 23 *AMA Definition of Peer Review*

24
25 AMA [Policy H-375.962](#), “Legal Protections for Peer Review,” defines peer review, in part, as:

26
27 . . . the task of self-monitoring and maintaining the administration of patient safety and quality
28 of care, consistent with optimal standards of practice . . . Peer review goes beyond individual
29 review of instances or events; it is a mechanism for assuring the quality, safety, and
30 appropriateness of hospital services. The duties of peer review are: addressing the standard of
31 care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that
32 the design of systems or settings of care support safety and high quality care . . .

33
34 Because peer review can involve close scrutiny of all aspects of patient care and safety, both with
35 respect to organization-wide patient care and safety issues and issues concerning individual
36 physicians and health care practitioners, the peer review process may bring to light serious patient
37 care and safety issues that are systemic to a hospital or other lay organization. Exposure of such

1 issues could damage the hospital's or organization's reputation in its community or its other
2 business interests. Consequently, a physician may be reluctant to participate in a peer review
3 proceeding for fear of retaliation if the physician believes that the hospital or lay organization will
4 take issue with the result of, or the physician's role in, that proceeding. This fear is exacerbated if
5 the hospital or lay organization dominates the physician's community. Thus, to ensure effective
6 peer review, physician peer review participants must be protected from the possibility of
7 retaliation.

8
9 *Market Developments: Physician Employment by Hospitals and Non-physician Entities and*
10 *Increasing Hospital Consolidation*

11
12 Physician concerns about retaliation against physician peer review participants have grown as
13 hospitals employ more physicians and hospital markets become more concentrated. Many
14 communities in the United States are dominated by only a few hospitals, or even by a single
15 hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or
16 other powerful lay organizations, some physicians increasingly fear retaliation for expressing
17 patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer
18 review process, that the hospital or organization perceives as being contrary to its financial
19 interests. For employed physicians, employment contract termination may be the greatest concern,
20 since termination may have an immediate and detrimental effect on the physician's ability to
21 continue practicing medicine in the community, e.g., if the termination triggers a broad restrictive
22 covenant.

23
24 Independent physicians may also fear retaliation. Although retaliation against an independent
25 physician would not involve employment termination, retaliation could take other forms, e.g.,
26 ending other kinds of contracts with the physician, such as a medical directorship or co-
27 management agreement; attempting to reduce or withdraw the physician's clinical privileges;
28 manipulating call, surgery, or procedure scheduling; or any other myriad means of making it
29 difficult, if not impossible, to fully and freely utilize hospital facilities and staff. If the hospital
30 dominates the physician's community, these kinds of retaliatory conduct could make it difficult, if
31 not impossible, for even an independent physician to maintain his or her medical practice in the
32 community.

33
34 *Peer Review Immunity under Federal Law: The Health Care Quality Improvement Act of 1986*

35
36 The Health Care Quality Improvement Act of 1986 (HCQIA), promotes peer review by
37 immunizing¹ those who participate in the peer review process from damages.² This immunity
38 applies if a decision by a professional review body, e.g., a decision to revoke hospital privileges, is
39 made using the following standards:

- 40
41
- 42 1. In the reasonable belief that the action was in the furtherance of quality health care;
 - 43 2. After a reasonable effort to obtain the facts of the matter;
 - 44 3. After adequate notice and hearing procedures are afforded to the physician involved or
45 after such other procedures as are fair to the physician under the circumstances; and
 - 46 4. In the reasonable belief that the action was warranted by the facts known after such
47 reasonable effort to obtain facts and after meeting the requirement of paragraph (3).³

48 Decisions made by a peer review body are presumed to have met standards (1) through (4) above,
49 although this presumption may be rebutted by a preponderance of the evidence.⁴

1 HCQIA was enacted over 30 years ago, when most physicians practiced independently and hospital
2 markets were not nearly as concentrated as they are today. HCQIA immunity is designed to protect
3 peer reviewers and others who participate in the peer review process, e.g., those who provide
4 information to peer review committees, from damage awards that might result from lawsuits filed
5 by individuals who have been adversely affected by peer review decisions. HCQIA does not
6 explicitly limit immunity from damages solely to lawsuits brought by adversely affected
7 physicians. Consequently, it is possible that a court could interpret HCQIA immunity to extend to
8 damages resulting from lawsuits filed by other parties, e.g., a hospital. However, court decisions
9 have up to this point focused on damage claims by adversely affected physicians, so it is unclear if,
10 and how, HCQIA immunity would apply in the context of lawsuits filed by other parties. Likely a
11 greater concern within the context of AMA Policy D-375.987 is that HCQIA immunity applies
12 when a lawsuit is involved. Consequently, immunity would seem not to apply to a wide variety of
13 retaliatory actions that a hospital or other lay organization might take against a peer reviewer, for
14 example, terminating an employment agreement or hindering an independent physician's ability to
15 fully and freely utilize hospital facilities or practice amenable in association with other physicians
16 employed by, or affiliated with, the hospital or organization.

17
18 *Amending HCQIA*

19
20 Although it is possible that an attempt could be made to amend HCQIA to pursue the goals of
21 AMA Policy D-375.987 your Board of Trustees does not, at this time, recommend attempting to
22 amend HCQIA to address a peer review-related retaliation. First, Congressional attention is entirely
23 taken up with a backlog of urgent "must pass" legislation. In this challenging and rapidly changing
24 environment, it would be extremely difficult to draw Congressional attention to yet another major
25 piece of health care legislation, particularly since amending HCQIA has not in recent years been an
26 issue with which Congress has been actively interested. Second, pursuing a HCQIA amendment
27 strategy at this time could have significant, negative unintended consequences, especially with
28 respect to the National Practitioner Data Bank (NPDB). The enactment of HCQIA created the
29 NPDB. In the past, some parties, whose interests are not aligned with those of organized medicine,
30 have strongly urged Congress to amend HCQIA so that the information in the NPDB would be
31 publicly available. Our AMA opposes such efforts. In fact, AMA Policy [H-355.976](#), "National
32 Practitioner Data Bank," states in part:

33
34 . . . 3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public
35 access; (b) strongly opposes public access to medical malpractice payment information in the
36 National Practitioner Data Bank; and (c) opposes the implementation by the National
37 Practitioner Data Bank of a self-query user fee . . .

38
39 Our AMA has taken this position because information in the NPDB is often incomplete and
40 inaccurate, not organized in a way that patients will understand, and is thus highly likely to be
41 misunderstood or misinterpreted by patients. For these reasons, then, your Board of Trustees does
42 not recommend attempting to amend HCQIA. However, while your Board does not believe that
43 pursuing a HCQIA amendment would be appropriate at this time, your Board feels strongly that
44 our AMA should provide assistance to any state medical association or national medical specialty
45 society that wants to explore or pursue a state legislative strategy to protect physician peer review
46 participants from retaliation.

47
48 *Peer Review Immunity under State Law*

49
50 The vast majority, if not all, states, have enacted peer review immunity laws. The conditions for
51 immunity are usually less demanding or specific compared to HCQIA's. HCQIA immunity is

1 available only if a decision by a peer review body satisfies standards (1) through (4) above. Under
2 most state peer review laws, immunity is available to peer review participants who act in good
3 faith.⁵ State peer review immunity extends to damages. In some circumstances, states go further,
4 immunizing peer review participants from civil liability generally, which would also protect peer
5 review participants from injunctions.⁶

6
7 State peer review laws are designed to protect peer review participants from lawsuits by physicians
8 or health care practitioners who feel that they have been aggrieved by a peer review decision. In
9 many states, immunity protections may not be explicitly limited to lawsuits filed by these
10 individuals. In such cases, like HCQIA, it is uncertain if, or to what extent, immunity would apply
11 if a party other than the individual adversely affected by a peer review decision filed a lawsuit
12 against one or more peer review participants. However, the more important issue with respect to
13 AMA Policy D-375.987 is that, like HCQIA, state peer review immunity protections apply to
14 lawsuits. Consequently, state peer review laws would likely not protect physician peer review
15 participants from the gamut of retaliatory actions short of a lawsuit that might be taken against
16 them for their role in, or a decision resulting from, a peer review proceeding.

17
18 Unlike HCQIA, most, if not all, states protect the confidentiality of peer review information. This
19 means that peer review information, documents and records cannot lawfully be disclosed to anyone
20 except those conducting the peer review and any other specific individuals or entities identified in
21 the peer review statute. Similarly, states often privilege peer review information, documents and
22 records of peer review proceedings, meaning that such information, documents and records are not
23 admissible in lawsuits, such as those involving medical liability allegations.

24 25 *State Court Decisions*

26
27 Although state court decisions involving state peer review statutes have focused on lawsuits by
28 persons adversely affected by a peer review decision, there is a reported case that does involve a
29 situation where a hospital retaliated against a peer review participant. The New Mexico Supreme
30 Court case of Yedidag, MD, v. Roswell Clinic Corp., 346 P.3d 1136 (2015) involved Emre
31 Yedidag, MD, a surgeon employed by Eastern Medical Center (EMC) and his alleged conduct
32 during a peer review proceeding. The proceeding focused on another physician's role in a patient
33 death. During the proceeding, Dr. Yedidag asked the physician a number of pointed questions to
34 clarify the circumstances of the patient's death, some of which the physician refused to answer.⁷ A
35 staff assistant to the peer review committee, who was not a committee member, attended the
36 meeting and later told hospital administration that Dr. Yedidag's questioning had been
37 inappropriately aggressive (even though physician peer review committee members found nothing
38 untoward about Dr. Yedidag's conduct).⁸ EMC subsequently fired Dr. Yedidag because of alleged
39 "unprofessional behavior."⁹ Dr. Yedidag sued EMC, claiming that EMC violated New Mexico's
40 peer review law. The New Mexico Supreme Court sided with Dr. Yedidag. The Court recognized
41 that the New Mexico peer review law did not "explicitly preclude employer retaliation for peer
42 review participation."¹⁰ Nor did the statute explicitly authorize Dr. Yedidag to file a lawsuit for
43 violations of the peer review law. However, the law did protect the confidentiality of peer review
44 information. The law also permitted use and disclosure of such information only for specific
45 reasons listed in the statute, and those reasons did not include the hospital's acquisition and use of
46 peer review information as part of its personnel decisions. Consequently, the Court ruled that the
47 hospital violated Dr. Yedidag's right to confidentiality under New Mexico's peer review law.

48
49 Although Dr. Yedidag won his lawsuit, this decision does not sufficiently address the issues raised
50 by D-375.987. First, the Yedidag case is a single decision under one state's law. Although most, if
51 not all, states protect the confidentiality of peer review information, state laws can vary

1 significantly in the scope of this protection. There is, therefore, no guarantee that other states would
2 reach the same result. Second, hospitals and other lay organizations do not necessarily need access
3 to confidential peer review information to retaliate against peer review participants. Thus, even if
4 all states ultimately followed the Yedidag decision, doing so would probably not cover all of the
5 instances in which a hospital or other lay organization could retaliate against a physician peer
6 review participant. Consequently, physician advocates wanting to address the issues identified by
7 D-375.987 may want to explore or pursue a state-based legislative strategy to ensure that physician
8 peer review participants are protected from all forms of retaliation.

9
10 *State Legislative Efforts to Protect Physician Peer Review Participants from Retaliation*

11
12 While it is extremely unlikely that HCQIA could be successfully amended at this time, the
13 prospects of amending a particular state's laws might be more promising. Your Board of Trustees
14 understands the serious concerns that AMA Policy D-375.987 raises. Your Board believes,
15 therefore, that our AMA should make its Advocacy Resource Center staff and resources available
16 to assist state medical associations and national medical specialty societies that may be interested
17 in considering or pursuing a state legislative strategy to protect physician peer review participants
18 from any retaliatory conduct by hospitals, lay organizations or other parties.

19
20 *AMA Policy*

21
22 AMA policies call for retaliation protections. The following is a list of relevant portions of AMA
23 policies. First, AMA Policy [H-225.950](#), "Principles for Physician Employment," states, in part,
24 that:

25
26 . . . 1.b. [e] mployed physicians should be free to exercise their personal and professional
27 judgment in voting, speaking, and advocating on any matter regarding patient care interests, the
28 profession, health care in the community, and the independent exercise of medical judgment.
29 Employed physicians should not be deemed in breach of their employment agreements, nor be
30 retaliated against by their employers, for asserting these interests . . .

31
32 Next, AMA Policy [H-225.952](#), "The Physician's Right to Exercise Independent Judgement in All
33 Organized Medical Staff Affairs," states that:

34
35 [o]ur AMA supports the unfettered right of a physician to exercise his/her personal and
36 professional judgment in voting, speaking and advocating on any matter regarding: [i] patient
37 care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters;
38 [v] the independent exercise of medical judgment as appropriate interests to be incorporated
39 into physician employment and independent contractor agreements; the right [vi] not to be
40 deemed in breach of his/her employment or independent contractor agreement for asserting the
41 foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any
42 way, including, but not limited to, termination of his/her employment or independent
43 contractor agreement, commencement of any disciplinary action, or any other adverse action
44 against him/her based on the exercise of the foregoing rights.

45
46 Further, AMA Policy [H-230.965](#), "Immunity from Retaliation Against Medical Staff
47 Representatives by Hospital Administrators," states that:

48
49 [t]he AMA condemns any action taken by administrators or governing bodies of hospitals or
50 other health care delivery systems who act in an administrative capacity to reduce or withdraw

1 or otherwise prevent a physician from exercising professional privileges because of medical
2 staff advocacy activities unrelated to professional competence, conduct or ethics.

3
4 AMA Policy [H-225.942](#), “Physician and Medical Staff Member Bill of Rights,” asserts, in part,
5 that:

6
7 . . . II. Our AMA recognizes that the following fundamental rights of the medical staff are
8 essential to the medical staff’s ability to fulfill its responsibilities: . . .b. The right to advocate
9 for its members and their patients without fear of retaliation by the health care organization’s
10 administration or governing body . . .

11
12 AMA Policy [H-225.942](#) also contains the following:

13
14 . . . IV. Our AMA recognizes that the following fundamental rights apply to individual medical
15 staff members, regardless of employment, contractual, or independent status, and are essential
16 to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical
17 staff, and the health care organization: . . .c. The right to exercise personal and professional
18 judgment in voting, speaking, and advocating on any matter regarding patient care or medical
19 staff matters, without fear of retaliation by the medical staff or the health care organization’s
20 administration or governing body . . .

21
22 In addition, AMA Policy [H-225.957](#), “Principles for Strengthening the Physician-Hospital
23 Relationship,” states that:

24
25 . . . 6. The organized medical staff has inherent rights of self-governance, which include but are
26 not limited to: . . .c) Identifying the indications for automatic or summary suspension, or
27 termination or reduction of privileges or membership in the organized medical staff bylaws,
28 restricting the use of summary suspension strictly for patient safety and never for purposes of
29 punishment, retaliation or strategic advantage in a peer review matter . . .

30
31 Finally, it is notable that our AMA also has policies calling for peer review immunity, two of
32 which are most relevant to this report. First, AMA Policy [H-375.962](#), “Legal Protections for Peer
33 Review,” states, in part, as follows:

34
35 . . . Peer Review Immunity. To encourage physician participation and ensure effective peer
36 review, entities and participants engaged in peer review activities should be immune from civil
37 damages, injunctive or equitable relief, and criminal liability . . .

38
39 Likewise, AMA Policy [H-225.942](#), “Physician and Medical Staff Member Bill of Rights,” states, in
40 part, that the rights of individual medical staff members must include: “. . . f. The right to immunity
41 from civil damages, injunctive or equitable relief, and criminal liability when participating in good
42 faith peer review activities . . .”

43
44 Although protection from any kind of retaliation because of peer review participation might be
45 implied from AMA policies, AMA policies do not explicitly call for such protection in the context
46 of peer review participation. This report, therefore, recommends amending AMA Policies
47 H-225.942 and H-375.962 to explicitly include protection from any retaliatory conduct.

1 RECOMMENDATIONS

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The Board of Trustees recommends that the following be adopted per AMA Policy D-375.987, and that the remainder of the report be filed:

1. That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition as follows:

. . . IV. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy);

2. That AMA Policy H-375.962, "Legal Protections for Peer Review," be amended by addition as follows:

. . . Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. (Modify Current HOD Policy); and

3. That our AMA will provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies. (Directive to Take Action)

Fiscal Note: \$5000.

APPENDIX

D-235.984, “Medical Staff Non-Punitive Reporting Processes”

Our AMA will provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community”

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician’s exercise of his/her rights under this paragraph.

REFERENCES

¹ Unlike state peer review laws, HCQIA does not address the confidentiality of peer review information or records of peer review proceedings. Nor does HCQIA address the issue of whether, or to what extent, peer review information, documents, or records may be admitted into lawsuits or administrative proceedings. The Confidentiality and admission of peer review information is determined by courts on a case-by-case basis.

² See 42 U.S.C. §§ 11101, et seq.

³ 42 U.S. Code § 11112(a)

⁴ Id.

⁵ See e.g., Rev. Code of Wash. § 4.24.240.

⁶ Id.

⁷ Yedidag, at 1143.

⁸ Id. at 1143-1144.

⁹ Id. at 1144.

¹⁰ Id. at 1151.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-17

Subject: Medical Reporting for Safety-Sensitive Positions
(Resolution 14-A-16)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Board of Trustees Report 8-I-16, “Medical Reporting for Safety Sensitive Positions,” which sought
2 to address Resolution 14-A-16 of the same title, was referred at the 2016 Interim Meeting of the
3 AMA House of Delegates. Testimony indicated that the report content missed the resolution’s
4 original intent. Although there are systems in place to screen pilots and others in safety sensitive
5 positions for serious medical conditions, it was stated that these patients often look for medical care
6 outside of these systems, and subsequently fail to be reported.

7
8 The Board of Trustees conferred with the authors to clarify the intent of Resolution 14-A-16. This
9 report alerts physicians that they may have new responsibilities as a result of changes in regulations
10 of the Federal Aviation Administration (FAA) regarding medical certification of pilots. It addresses
11 the implications of these changes for pilot and public safety.

12 BACKGROUND

13
14
15 Effective May 1, 2017, pilots of certain small aircraft may elect to participate in the FAA’s new
16 “BasicMed” program, which allows any licensed physician to evaluate a pilot’s medical fitness to
17 fly. If pilots meet conditions for participating in BasicMed, they are no longer *required* to obtain
18 third class medical certification specifically from an FAA-designated Aviation Medical Examiner
19 (AME) [1]. Pilots in the designated category may continue to seek third class medical certification
20 from an aviation medical examiner if they choose.

21
22 To be eligible for privileges in BasicMed, pilots must have a valid U.S. driver’s license, have held
23 third class medical certification at some time since July 15, 2006 (which must not have been
24 revoked, suspended or withdrawn), and not have been denied third class certification on their most
25 recent application [2]. The individual must have documented completion of an FAA-approved
26 online medical education course within the past 24 months; have had a physical examination by a
27 licensed physician, who reviewed the FAA’s Comprehensive Medical Examination Checklist
28 completed by the patient, within the past 48 months; and must consent to a National Driver
29 Register check.

30
31 Individuals who have a medical history or clinical diagnosis of personality disorder repeatedly
32 manifested by overt acts, psychosis, bipolar disorder, or substance dependence (within the previous
33 two years) must obtain a “special issuance medical certification” from an aviation medical
34 examiner before they may exercise privileges under BasicMed [2]. Similarly, a history or diagnosis
35 of epilepsy or disturbance of consciousness or transient loss of control of nervous system function
36 absent satisfactory medical explanation of cause entails that the individual obtain a special issuance

1 medical certification before he or she may exercise privileges under BasicMed. Further these
 2 individuals must be under the care of a physician for the condition.

3
 4 Individuals are prohibited from exercising privileges under BasicMed if their driver’s license has
 5 been revoked as a result of the diagnosed condition or if, “in the judgment of the individual’s state-
 6 licensed physician,” the individual is unable or “may reasonably be expected to be unable” to
 7 safely exercise those privileges as a result of the condition [2].

8
 9 **PILOT SAFETY — PUBLIC SAFETY**

10
 11 The goal of medical certification, for all classes of pilots, is to ensure public safety. Recent aviation
 12 incidents, notably the crash of Germanwings Flight 9525 in 2015, which killed 150 passengers and
 13 crew, have raised questions about whether oversight of pilots’ medical status and safety to fly is
 14 sufficiently rigorous. FAA requirements covering pilots who fly for commercial airlines, i.e., who
 15 hold transport pilot certification, or those who hold commercial pilot certification and may fly for
 16 hire, are not affected by the regulatory changes that created BasicMed. Even under the more
 17 stringent standards governing these classes of pilots there is concern that pilots with potentially
 18 impairing medical conditions may be permitted to fly when they are in fact unsafe [3]. These
 19 questions form the backdrop to challenges that BasicMed poses for physicians in the U.S.

20
 21 *Medical Certification of Aviators*

22
 23 Aviation Medical Examiners are specifically authorized by the FAA to carry out pilot medical
 24 examinations for purposes of protecting the public. To become an AME, physicians must apply to
 25 and complete training developed by the Aerospace Medical Education Division of the FAA Civil
 26 Aerospace Medical Institute [4]. Prospective AMEs are required to complete online course work as
 27 well as four and a half days of in-person training and to complete refresher training every 36
 28 months [4]. Among other objectives, in-person training is intended to:

- 29
 30 • Review the latest medical and technical information and clinical examination techniques in the
 31 various medical specialty fields that an AME will need to use to assure that aviators meet the
 32 medical certification standards for the class of aviator medical certificate applied for [and]
 33 • Recognize the basis for disqualification of the aviator with a medical problem and the
 34 conditions necessitating deferral or denial as outlined in Federal Aviation Regulations [5]
 35

36 In 2012, the Aerospace Medical Association Ad Hoc Working Group on Pilot Mental Health noted
 37 that “serious mental health issues involving sudden psychosis are relatively rare, and their onset is
 38 difficult to predict,” but that “more attention should be given to mental health issues during the
 39 aeromedical assessment of pilots” [6]. The group recommended that “physicians performing
 40 aeromedical assessments receive additional periodic training in aviation mental health issues” [6].
 41 In a letter to the FAA of September 2015 following the report on the Germanwings incident, the
 42 working group reiterated its recommendation that more attention be given “to less serious and more
 43 common mental health conditions,” including grief, psychosocial stress, depression, anxiety, panic
 44 disorders, personality disorders, and substance misuse/abuse, noting that these conditions “show
 45 patterns that facilitate early detection, and have proven effective treatment strategies” [6,7].
 46

47 The working group also reiterated and expanded on its previous recommendation to create a “safe
 48 zone” to encourage frank discussion of mental health issues [6], urging that “methods be used to
 49 build rapport and trust with the pilot in a nonthreatening environment” [7]. It also more explicitly
 50 identified barriers to frank discussion, noting that pilots are “highly independent, value control, and
 51 fear losing their medical certification.” The 2015 guidelines reiterated the call for additional

1 training in aviation mental health issues for physicians who conduct aeromedical assessments, and
2 called for training to include guidance for when the aeromedical examiner should consult with or
3 refer the pilot to “a mental health specialist provider or other aeromedical resource.”

4
5 *The Challenge for Non-AME Physicians*

6
7 When AMEs who are under contract to commercial air carriers or other commercial entities
8 conduct examinations of pilot-employees, they are required to report their findings to the pilot’s
9 employer as well as to the FAA. When they conduct examinations of aviator applicants
10 independently (i.e., not while under contract to the employer), AMEs must report all findings to the
11 FAA without fail. In the latter situation, individuals who do not receive medical certification are
12 expected to voluntarily refrain from piloting aircraft pending further evaluation by FAA medical
13 experts. On a few occasions the aviator applicants are permanently restricted from medical
14 certification and cannot legally fly any aircraft.

15
16 A pilot exercising the privileges of BasicMed may be examined by any physician licensed by any
17 U.S. state, territory or possession. The physician is required to report potentially impairing
18 conditions in keeping with state regulations governing the issuance of motor vehicle licenses. The
19 examining physician must review the individual’s completed FAA Comprehensive Medical
20 Examination Checklist with the pilot, but is not required to report to the FAA.

21
22 Questions have been raised about how well this process protects both pilots and the public interest.
23 Non-AME physicians may not be adequately prepared to fulfill this new responsibility. Non-AME
24 physicians need to be made aware of the responsibility itself and of resources available to them,
25 including consulting with or referring a patient to a regional Aviation Medical Examiner.

26
27 In addition, laws governing reporting of medical conditions that may impair an individual’s ability
28 to operate a motor vehicle safely vary from state to state. Whether pilots who are eligible for
29 privileges under BasicMed, but may be impaired, present a greater risk to safety than drivers who
30 may be impaired is not necessarily at issue. What is of concern are data suggesting that even in
31 jurisdictions where physicians are required to report potentially impairing conditions for motor
32 vehicle operators they do not uniformly do so [8].

33
34 *Confidentiality & Trust*

35
36 Effective patient-physician relationships require that patients be willing to share sensitive
37 information with their physicians. Patients must be able to trust that information they give to their
38 physicians in confidence will be protected, and physicians have a corresponding duty to protect the
39 confidentiality of patients’ personal information [9–12]. Patients who fear the consequences of
40 disclosure, particularly disclosure of stigmatizing conditions, may be reluctant to seek treatment.
41 However, the right to confidentiality is not without limits. In many situations, physicians may be
42 required to breach confidentiality for purposes of protecting the health or safety of the community,
43 as in mandatory reporting of infectious disease to public health authorities or required reporting of
44 potentially impaired drivers [13].

45
46 Physicians may also disclose personal health information without patients’ consent when in the
47 physician’s professional judgment there is a reasonably probability of serious harm to the patient or
48 serious harm to other identifiable individual(s) [15]. Industry-employed physicians and
49 independent medical examiners may likewise disclose to third parties [16]. In all instances,
50 however, physicians are expected to restrict disclosure to the minimum information necessary for

1 the specific purpose at hand and, whenever feasible, to notify the patient in advance of the
2 disclosure.

3

4 RECOMMENDATION

5

6 In light of these considerations, the Board of Trustees recommends that the following be adopted
7 and the reminder of this report be filed:

8

- 9 1. That our American Medical Association (AMA) promote awareness among all licensed
10 physicians of the safety implications of mental health and other potentially impairing
11 conditions for their patients who are aviator. Physicians need to be aware that for some patients
12 the FAA's BasicMed program now makes the treating physician a gatekeeper for pilot and
13 public safety. Physicians who are not FAA Aviation Medical Examiners should be educated
14 about when to seek guidance from colleagues with aeromedical expertise. Physicians should
15 also recognize that the range of mental health conditions in particular that may compromise an
16 aviator's ability to fly safely is more extensive than the specific conditions identified in the
17 FAA Comprehensive Medical Examination Checklist. (New HOD Policy)
- 18
- 19 2. That our AMA urge physicians to screen routinely for factors that may compromise pilot safety
20 by the least intrusive means reasonable and take steps with the patient to mitigate identified
21 risks. Physicians should be encouraged to consult with or refer the patient to the appropriate
22 FAA Aviation Medical Examiner or FAA Regional Flight Surgeon. (New HOD Policy)
- 23
- 24 3. That our AMA advocate for adoption of a uniform mechanism for reporting aviators who have
25 potentially compromising medical conditions. (New HOD Policy)
- 26
- 27 4. That the Council on Ethical and Judicial Affairs be encouraged to review implications for
28 existing ethics guidance in light of the FAA's alternative requirements for pilot physical
29 examination and education codified in BasicMed. (New HOD Policy)

Fiscal Note: Less than \$1000.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-17

Subject: Amended Bylaws – Specialty Society Representation – Five-Year Review

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 At the 2017 Annual Meeting, the House of Delegates considered Board of Trustees Report 25,
2 “Specialty Society Representation in the House of Delegates – Five-Year Review.” Among its
3 recommendations was that two societies which failed to meet the requirements for continued
4 representation after a year’s grace period to increase membership should not retain representation
5 in the House of Delegates. Testimony at the Reference Committee on Amendments to Constitution
6 and Bylaws, however, supported maintaining the inclusion of these two societies. Testimony
7 lauded the groups’ growths in membership and their participation within the AMA, and maintained
8 that the loss of these societies would be detrimental to the AMA. Both societies presented materials
9 to the reference committee outlining their considerable efforts to increase membership. Based on
10 the testimony presented, the Reference Committee on Amendments to Constitution and Bylaws
11 recommended that the societies retain their representation.
12

13 The House of Delegates disagreed and chose to adopt amended language as follows, “Having failed
14 to meet the requirements for continued representation in the AMA House of Delegates as set forth
15 in AMA Bylaw B-8.5 after a year’s grace period [both societies]... be allowed only one additional
16 year to meet these requirements.” The following day, the House reconsidered this item of business
17 because our current Bylaws do not contain an option for the House to extend a second one-year
18 grace period. Ultimately, the House returned to the original BOT Report 25-A-17 recommendation
19 to not retain the representation of these two societies in the House of Delegates. Although the
20 AMA Bylaws do allow the House to continue the representation of a society that does not meet the
21 current guidelines for representation, some testified that this is unfair to those societies that have
22 faced similar membership challenges but succeeded in regaining membership during the one-year
23 grace period. Lastly, a representative of the Specialty and Service Society (SSS) stated that, per the
24 AMA Bylaws, each of the two societies, though they would not retain representation in the HOD,
25 would continue as a member of the SSS and may apply for reinstatement in the House, through the
26 SSS, when they believe they can comply with the guidelines for representation in the House of
27 Delegates.
28

29 The Council on Constitution and Bylaws volunteered to look at the existing bylaws and bring forth
30 a report back to the House.
31

32 HISTORICAL PERSPECTIVE/CURRENT STATUS 33

34 As part of its due diligence, the Council examined the origin of direct specialty society
35 representation in the AMA House of Delegates. Specialty societies were first directly represented
36 in the House of Delegates in 1977. Ten years later in 1987, there were major changes, including

1 guidelines for evaluating applications for representation and establishing a five-year review to
2 ensure continued compliance with the guidelines.

3
4 The first instance of noncompliance arose in 1989. Subsequently the House, through the Council
5 on Long Range Planning and Development (CLRPD), began to consider various options, including
6 a grace period, automatic disqualification of the specialty organization, and a probationary period
7 without voting privileges. It took three meetings for the House to ultimately agree on bylaw
8 language that provided for an automatic one-year grace period to allow noncompliant societies time
9 to become compliant, another review of the society a year later, and the following three options for
10 House action on any society that remained noncompliant after the one-year grace period:

11 1) continued representation; 2) termination of representation; or 3) a year of probation defined as
12 suspension from active representation, with the society on probation not having a voting delegate in
13 the House or the privilege of the floor, but continued representation in the Specialty Section
14 Council. During the probation period, one final review of the society's compliance with the current
15 guidelines would occur. If the specialty organization failed to bring itself into compliance, it then
16 would automatically be terminated from representation in the House of Delegates.

17
18 In 1993, the House adopted CLRPD Report B-A-93, which provided substantive recommendations
19 for restructuring the House of Delegates. This report also established the Specialty and Service
20 Society (SSS) as the entity responsible for providing a process for: 1) granting specialty
21 organization representation in the House; 2) periodic review of the qualifications of specialty
22 organizations for retention of representation; and 3) a mechanism for terminating, when
23 appropriate, the representation of a specialty organization in the House. The work of SSS is
24 overseen by an 8-person governing council, which is elected by the SSS membership. CCB Report
25 2-A-94 provided the bylaw amendments to implement the mechanism by which specialty
26 organizations were admitted to the House and by which they maintained their representation, but
27 deleted the previous bylaw language providing for automatic termination after the one-year
28 probationary period.

29
30 Under the current Bylaws, all specialty societies are reviewed on a five-year cycle to determine
31 compliance with the current guidelines as stated in AMA policy (Policy G-600.020). The Bylaws
32 provide noncompliant societies with a one-year grace period during which it is hoped that they are
33 able to bring themselves into compliance. At the end of that period, the House has only two options
34 for acting on societies that remain noncompliant after the one-year grace period: 1) continue the
35 society's representation; or 2) discontinue the society's representation.

36
37 The appended chart shows the evolution of specialty society representation once the five-year
38 review was put into place, offers more details regarding amendments over time to the AMA
39 Bylaws to address noncompliant societies, and provides background on House actions on
40 noncompliant societies. In short, since 1989 there have been 69 societies that did not meet the
41 guidelines for continued representation, with House action characterized as follows:

- 42
43 • Society compliant after grace period – 38
44 • Society noncompliant/representation continued – 17
45 • Society noncompliant/representation terminated – 7 (two of these societies were subsequently
46 readmitted)
47 • Other action – 7 (society dissolved, society merged with another, etc.)
48

49 It must also be noted that 10 years ago, a fairly large number of societies up for review were no
50 longer able to meet the current guidelines for representation due to declining AMA membership
51 among their own specialty society membership. The House placed a moratorium on loss of

1 representation, and in 2008 subsequently adopted modified membership criteria, which were again
2 amended in 2012 and embodied in Policy G-600.020 (3).

3
4 DISCUSSION

5
6 The Council identified and discussed several elements it believed were not clearly addressed in
7 current AMA Bylaws and convened a conference call with members of the SSS Governing
8 Council. Discussion points included:

9
10 1) *When does a specialty society's termination from representation in the House of Delegates*
11 *take effect?*

12
13 Historically, the loss of representation has occurred at the conclusion of the meeting rather than
14 immediately following the House's action to unseat. This seems fair to the Council, as any
15 organization with a one-year grace period that is invested enough in the outcome to send a
16 representative without knowing the outcome in advance should not be penalized by
17 immediately losing their seat or voting privileges. An amendment to the Bylaws to this effect
18 has been proposed for House action.

19
20 2) *When does the next five-year review occur for a noncompliant society when the House votes to*
21 *continue its representation in the House after a one-year grace period?*

22
23 Every specialty admitted to the House of Delegates is on a five-year review cycle. In the past,
24 SSS has maintained the original five-year review schedule. Thus, when the House votes to
25 continue the representation of a noncompliant society after a grace period, the specialty society
26 retains representation in the House of Delegates until its next scheduled review with no
27 additional scrutiny or reporting. The Council has proposed Bylaw language to make this
28 clearer.

29
30 3) *What actions, if any, beyond those in the current Bylaws should the House be empowered to*
31 *take when faced with a society that remains noncompliant after its one-year grace period?*

32
33 Both the Council and the SSS agree that it is the responsibility of the House to decide to either
34 continue the membership with another review in 4 years or to terminate the society's
35 representation. In the past, the House has been inconsistent in its actions, often being swayed
36 by passionate testimony during reference committee and again on the floor of the House on
37 why a society should not lose its representation. In light of the recent parity in representation
38 between constituent societies and specialty societies, essentially any nonconforming society
39 whose representation is continued is taking a seat from another specialty society that has met
40 all requirements for continued representation. SSS members expressed hopes that the House
41 would be judicious in actions to continue the representation of any society that is
42 noncompliant, reserving the vote for continuation only for extenuating circumstances. Also, per
43 existing AMA Bylaw 8.5.3.2.2, if the House votes to terminate a specialty society's
44 representation in the House, they still remain members of the Specialty and Service Society. A
45 society, which worked hard during its grace period but did not reach its goal but that continued
46 its outreach efforts, likely would be without an HOD delegate seat for less than one year even
47 recognizing that new societies are only admitted at the Annual Meeting. The Council believes
48 the options currently provided in the Bylaws should remain as the only options.

1 RECOMMENDATIONS

2
3 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
4 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative
5 vote of two-thirds of the members of the House of Delegates present and voting.
6

7 **8.5 Periodic Review Process.** Each specialty society and professional interest medical
8 association represented in the House of Delegates must reconfirm its qualifications for
9 representation by demonstrating every 5 years that it continues to meet the current
10 guidelines required for granting representation in the House of Delegates, and that it has
11 complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and
12 recommend that societies currently classified as specialty societies be reclassified as
13 professional interest medical associations. Each specialty society and professional interest
14 medical association represented in the House of Delegates must submit the information and
15 data required by the SSS to conduct the review process. This information and data shall
16 include a description of how the specialty society or the professional interest medical
17 association has discharged the responsibilities required under Bylaw 8.2.
18

19 **8.5.1** If a specialty society or a professional interest medical association fails or refuses
20 to provide the information and data requested by the SSS for the review process, so
21 that the SSS is unable to conduct the review process, the SSS shall so report to the
22 House of Delegates through the Board of Trustees. In response to such report, the
23 House of Delegates may terminate the representation of the specialty society or the
24 professional interest medical association in the House of Delegates by majority
25 vote of delegates present and voting, or may take such other action as it deems
26 appropriate.
27

28 **8.5.2** If the SSS report of the review process finds the specialty society or the
29 professional interest medical association to be in noncompliance with the current
30 guidelines for representation in the House of Delegates or the responsibilities
31 under Bylaw 8.2, the specialty society or the professional interest medical
32 association will have a grace period of one year to bring itself into compliance.
33

34 **8.5.3** Another review of the specialty society's or the professional interest medical
35 association's compliance with the current guidelines for representation in the
36 House of Delegates and the responsibilities under Bylaw 8.2 will then be
37 conducted, and the SSS will submit a report to the House of Delegates through the
38 Board of Trustees at the end of the one-year grace period.
39

40 **8.5.3.1** If the specialty society or the professional interest medical association is
41 then found to be in compliance with the current guidelines for
42 representation in the House of Delegates and the responsibilities under
43 Bylaw 8.2, the specialty society or the professional interest medical
44 association will continue to be represented in the House of Delegates and
45 the current review process is completed. The next review will occur four
46 years from the time of the House's action to continue representation.
47

48 **8.5.3.2** If the specialty society or the professional interest medical association is
49 then found to be in noncompliance with the current guidelines for
50 representation in the House of Delegates, or the responsibilities under
51 Bylaw 8.2, the House ~~may~~ must take one of the following actions:

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8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1. The next review will occur four years from the time of the House's action to continue representation after a one-year grace period.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates effective with the adjournment of the House of Delegate meeting at which action takes place. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

RELEVANT AMA POLICY

G-600.020, “Admission of Specialty Organizations to our AMA House”

The following guidelines shall be utilized in evaluating specialty society applications for representation in our AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):

- (1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership;
- (2) The organization must: (a) represent a field of medicine that has recognized scientific validity; (b) not have board certification as its primary focus; and (c) not require membership in the specialty organization as a requisite for board certification;
- (3) The organization must meet one of the following criteria: (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA;
- (4) The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
- (5) Physicians should comprise the majority of the voting membership of the organization.
- (6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
- (7) The organization must be active within its field of medicine and hold at least one meeting of its members per year;
- (8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
- (9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization;
- (10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

G-600.019, “Probationary Period for Specialty Societies”

The specialty organizations placed on one year probation are expected to work with AMA membership to develop a plan to increase their AMA membership and meet the responsibilities of National Medical Specialty Organizations as provided in Section 8.20 of the Bylaws.

Our AMA will work towards implementation of data licensing agreements with the specialty organizations seated in the House of Delegates that will provide them with the ability to view a portion of the AMA eprofile application for the sole purpose of AMA membership verification.

History of Specialty Societies noncompliant with AMA-HOD Representation Criteria and House Action

Society and Year of Initial Review for Compliance (and Year of Admittance)	Outcome/Comments
1989	<p>BOT Report DDD-A-89, in its review of the third group of specialty organizations seated in the HOD, noted the first society not in compliance. The Board was asked to develop a mechanism to address specialty society noncompliance and report back at I-89. CCB Report A-I-89, proposed a process, including a one-year grace period, to permit the House of Delegates to take direct action when a deficiency was discovered in the process of the five-year review, but it was referred back, as was CCB Report A-A-90. Ultimately adopted was CCB Report I-I-90 with its proposal that (1) there will be a verification of AMA membership of the specialty organization, and notification of the results of the review process provided to the specialty organization approximately one year prior to the BOT's report to the House; (2) A specialty organization found to be noncompliant will have one year, from the time of the Board's report to the HOD, to bring itself into compliance with the guidelines. At the end of the grace period of one year, the Board will submit another report advising the House as to the specialty organization's compliance. If the organization is not in compliance, the House will have the option of voting to continue the representation of the specialty organization in the HOD, to terminate the representation in the HOD or to place the specialty organization on a probationary status for a period of one year. (Probationary status is defined as suspension from active representation. A society on probation would not have a voting delegate and would not have the privilege of the floor, but would be entitled to continue to have representation in the specialty Section Council.) If the HOD grants a one-year period of probationary status, the BOT shall report one year later, in an informational report, on the organization's compliance with the guidelines for representation. If the organization has failed to bring itself into compliance, it will be automatically terminated from representation in the House. CCB Report E-A-91 with the bylaw amendments was adopted.</p>
American Association of Pathologists (1977)	<p>A-89: No "official probation," but BOT reported it would again review membership data in 1990. BOT Report CCC-A-90 was adopted with the recommendation that AAP's representation be suspended at the conclusion of the 1990 Annual Meeting for a 2-year period, during which the AAP may be readmitted to representation in the HOD if it cures the cited deficiency and brings itself into compliance with the Guidelines for Representation in the House. At the conclusion of said two year period if the cited deficiency has not been corrected the representation of the AAP will be terminated.</p>

1990	
American College of Preventive Medicine (1977)	A-90: No “official probation” at time, but BOT stated it would (re)review membership data in 1991. A-91: ACPM fully compliant.
1991	
American Society of Clinical Pharmacology and Therapeutics (1977)	A-91: Given one year to correct its membership deficiency; and the Board to report back at A-92. A-92: Placed on probation for one year, thereby revoking its vote and floor privileges, and directed the Board to report back at A-93 on ASCPS’s number and percentage of AMA members, as well as its status as a seated specialty. A-93: Informational BOT reports ASCPT’s automatic termination due to continued noncompliance.
American Pediatric Surgical Association (1986)	A-91: Granted an extension to September 1991 to submit letter of compliance and BOT asked to report on APSA’s compliance at I-91. (Could find no follow-up report, but APSA represented in HOD until 1996.)
1992	
No noncompliant societies	
1993	
No noncompliant societies	
1994	
National Association of Medical Examiners (1983)	A-94: Granted one year to correct its membership deficiency. A-95: BOT reports NAME is compliant and recommends that its seat be retained.
American College of Legal Medicine (1984)	I-94: Granted one year to correct its membership deficiency. I-95: BOT recommends one additional year of probation to increase AMA membership. I-96: Representation terminated but ACLM allowed to continue its representation in SSS. A-10: Reapplied and accepted in 2010.
1995	
American College of Preventive Medicine (1977)	A-95: Granted one year to correct its membership deficiency. A-96: ACPM compliant.
1996	
American Society of Cytopathology (1982) [Admitted as American Society of Cytology]	I-96: Granted one year to correct its membership deficiency. I-97: Granted an additional year of probation. A-98: Representation retained (compliant).
1997	
American Society of Electrodiagnostic Medicine (1987)	I-97: Granted one year to correct its membership deficiency. A-98: Representation retained (compliant).

1998	
American Academy of Allergy, Asthma & Immunology (1977)	I-98: Granted one year to correct its membership deficiency. A-99: Representation retained (compliant).
1999	
Association of University Radiologists (1989)	A-99: Granted one year to correct its membership deficiency. [No follow-up report found but the society was reviewed and found to be compliant in cycles thereafter and continues to be represented in the HOD in 2017]
2000	
No noncompliant societies	
2001	
American Association of Clinical Endocrinologists (1996)	A-01: Granted one year to correct its membership deficiency. A-02: AACE removed from probation and representation retained.
2002	
The Endocrine Society (1996)	A-02: Noncompliance and one-year grace period noted, but no recommendation. A-03: Representation continued (compliant).
American College of Rheumatology (1987) [Admitted as the American Rheumatism Association]	I-02: Noncompliance and one-year grace period noted, but no recommendation. A-03: Representation continued (compliant)
Society of Nuclear Medicine (1979)	I-02: Noncompliance and one-year grace period noted, but no recommendation. A-03: Representation continued (compliant).
2003	
American Society of Addiction Medicine (1988)	A-03: Noncompliance noted and one year grace period noted, but no recommendation. A-04: Representation continued (compliant).
American Society of Ophthalmic Plastic and Reconstructive Surgery (1998)	A-03: Noncompliance noted and one year grace period noted, but no recommendation. I-03: representation continued (compliant).
2004	
National Association of Medical Examiners (1983)	I-04: Placed on a one-year grace period for review. I-05: Representation retained (noncompliant).
2005	
Society of Radiologists in Ultrasound (2000)	A-05: Placed on a one-year grace period for review. A-06: Representation discontinued at society's request.

2006	At A-06, the House adopted Resolution 603 that called for a moratorium on the loss of any organization's current representation in the HOD for any society which does not meet the current AMA guidelines for representation requirements as it pertains to the percentage of AMA members; that the moratorium remain in place through December 31, 2007; and when the moratorium is lifted any organization which does not meet the required percentage of AMA members will have a one year grace period to meet the requirements for HOD representation.
American College of Medical Genetics & Genomics (1996) [Admitted as American College of Medical Genetics]	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation retained (compliant with new membership threshold).
American Pediatric Surgical Association (1986)	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with new membership threshold).
American Society of Bariatric Physicians (2001)	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with the new membership threshold).
American Society of Colon and Rectal Surgeons (1977)	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with new membership threshold).
American Society of Neuroimaging (1996)	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with new membership threshold).
American Society of Neuroradiology (1986)	A-06: Placed on a one-year grace period for review. I-07: Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with new membership threshold).

Renal Physicians Association (1986)	A-06: Placed on a one-year grace period for review. A-07: Representation continued (compliant).
2007	
Academy of Pharmaceutical Physicians and Investigators (2002)	A-07: Did not submit materials (aware it will automatically be placed on probation at the end of the moratorium on December 31, 2007, and will be required to go through the five-year review process in 2008. Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance. I-08: Representation continued (compliant with new membership threshold).
Society of Nuclear Medicine (1979)	I-07: Placed on a one-year grace period for review at the AMA's 2008 Interim Meeting. I-08: Noncompliance noted but the House voted to continue their representation.
2008	
	The House adopted BOT Report 6-I-08 that amended AMA policy to specify a minimum of 100 AMA members (from 250) and twenty-five % (from thirty five percent) of its physicians as AMA members.
Aerospace Medical Association (1977)	I-08: Have a grace period of one year to bring themselves into compliance.
American Academy of Hospice & Palliative Medicine (2003)	A-08: Have a grace period of one year to bring themselves into compliance. A-09: Representation continued (noncompliant).
American Society of Addiction Medicine (1988)	I-08: Have a grace period of one year to bring themselves into compliance.
American Association for Hand Surgery (2003)	A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred) I-08: Representation continued (compliant with new membership threshold)
American Clinical Neurophysiology Society (1998)	A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred) I-08: Representation continued (compliant with new membership threshold)
American Society of Ophthalmic Plastic & Reconstructive Surgery (1998)	A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred) I-08: Representation continued (compliant with new membership threshold)
American Academy of Allergy, Asthma and Immunology (1977)	I-08: Noncompliance noted as well as a one-year grace period, but the House voted to continue representation.
2009	
American College of Nuclear Medicine (1979)	I-09: Did not submit information as it is in the process of merging with the College of Nuclear Physicians. The HOD voted to give it a one-year grace period to bring itself into compliance or be removed from the HOD. No further follow-up
2010	
American Geriatrics Society (1978) [Admitted as American Geriatric Society]	I-10: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-11: Representation continued (compliant).

American College of Occupational and Environmental Medicine (1977) [Admitted as American Academy of Occupational Medicine]	I-10: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-11: Representation continued (compliant).
2011	
AMDA—Society for Post-Acute and Long-Term Care Medicine (1991) [Admitted as American Medical Directors Association]	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation retained (noncompliant).
American Pediatric Surgical Association (1986)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation discontinued (did not submit materials and thus determined to be noncompliant; APSA notified they would no longer be participating).
American Society of Bariatric Physicians (2001)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation retained (noncompliant).
American Society of Neuroradiology (1996)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation retained (compliant).
Korean–American Medical Association (2006)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation discontinued (did not submit materials and thus determined to be noncompliant).
Renal Physicians Association (1986)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation retained (noncompliant).
Society of Interventional Radiology (1991)	A-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-12: Representation retained (compliant).
American Society of Radiation Oncology (1978) [Admitted as the American Society for Therapeutic Radiologists, later renamed ASTRO, American Society for Therapeutic Radiology and Oncology]	I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-12: Representation continued (noncompliant).

American Society for Surgery of the Hand (1996)	I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-12: Representation continued (noncompliant).
American Society of Cytopathology (1982) [Admitted as American Society of Cytology]	I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-12: Representation continued (noncompliant).
Society for Vascular Surgery (1996) [Admitted as International Society for Cardiovascular Surgery]	I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-12: Representation continued (noncompliant).
2012	
Academy of Physicians in Clinical Research (2002) [Admitted as American Academy of Pharmaceutical Physicians, later known as American Academy of Pharmaceutical Physicians and Investigators]	A-12: Reported as noncompliant at A-11. Representation continued (noncompliant).
American Society of Maxillofacial Surgeons (1987)	I-12: Reported as noncompliant. Representation continued (noncompliant).
Society of Nuclear Medicine and Molecular Imaging (1979) [Admitted as Society of Nuclear Medicine]	I-12: Reported as noncompliant. Representation continued (noncompliant).
2013	
American Academy of Hospice and Palliative Medicine (2003)	A-13: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-14: Representation continued (compliant).
2014	
American Society of Hematology (1989)	A-14: Given a grace period of one year to meet the membership requirements to retain position in the AMA HOD. A-15: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-16: Representation terminated (noncompliant). [Reapplied in 2017 and regained representation]
American College of Physician Executives (1989)	A-14: Representation terminated at the organization's request.

American College of Chest Physicians (1977)	I-14: Given six months to submit materials for consideration for continued representation or risk loss of representation. A-15: Representation retained (compliant).
National Association of Medical Examiners (1983)	I-14: Given a grace period of one year to meet the membership requirements to retain position in the AMA HOD. I-15: Representation continued (compliant).
Society of Medical Consultants to the Armed Forces (1978)	I-14: Representation terminated per the organization's request (sunset as an organization)
2015	
Heart Rhythm Society (2010)	A-15: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. I-15: Representation continued (compliant).
International Society for Hair Restoration Surgery (2010)	A-15: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD. A-16: Representation terminated (noncompliant).
2016	
American Association of Clinical Endocrinologists (1996)	A-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership. I-16: Representation continued (compliant).
American Association of Hip and Knee Surgeons (2001)	A-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership. A-17: Representation discontinued (noncompliant).
American Society of Neuroimaging (1989)	A-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership. A-17: Representation discontinued (noncompliant).
Society of Interventional Radiology (1991)	A-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership. A-17: Representation continued (compliant).
American Academy of Sleep Medicine (1996) [Admitted as American Sleep Disorders Association]	I-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.
American Society of Cytopathology (1982) [Admitted as American Society of Cytology]	I-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.

<p>American Society of Plastic Surgeons (1977) [Admitted as American Society of Plastic and Reconstructive Surgeons]</p>	<p>I-16: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</p>
<p>2017</p>	
<p>Academy of Physicians in Clinical Research (2002) [Admitted as American Academy of Pharmaceutical Physicians, later known as American Academy of Pharmaceutical Physicians and Investigators]</p>	<p>A-17: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</p>
<p>American Society of General Surgeons (1997)</p>	<p>A-17: Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</p>

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-I-17)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

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.

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. 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.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-17

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr, MD, Chair)

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

8
9 Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined
10 what the commitment to competence means as an ethical responsibility for individual physicians in
11 day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to
12 develop ethics guidance for physicians.

13 14 DEFINING COMPETENCE

15
16 A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional
17 assessments of physicians' technical knowledge and skills. However, this report is not concerned
18 with matters of technical proficiency assessed by medical schools and residency programs,
19 specialty boards (for purposes of certification), or hospital and other health care organizations (e.g.,
20 for privileging and credentialing). Such matters lie outside the Council's purview.

21
22 The ethical responsibility of competence encompasses more than knowledge and skill. It requires
23 physicians to understand that as a practical matter in the care of actual patients, competence is fluid
24 and dependent on context. Importantly, the ethical responsibility of competence requires that
25 physicians at all stages of their professional lives be able to recognize when they are and when they
26 are not able to provide appropriate care for the patient in front of them or the patients in their
27 practice as a whole. For purposes of this analysis, competence is understood as "the habitual and
28 judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values,
29 and reflection in daily practice for the benefit of the individual and the community being served"
30 and as "developmental, impermanent, and context dependent" [10].

31
32 Moreover, the Council is keenly aware that technical proficiency evolves over time—what is
33 expected of physicians just entering practice is not exactly the same as what is expected of mid-

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 career physicians or physicians who are changing or re-entering practice or transitioning out of
2 active practice to other roles. Each phase of a medical career, from medical school through
3 retirement, carries its own implications for what a physician should know and be able to do to
4 practice safely and to maintain effective relationships with patients and with colleagues.

5
6 The concept that informs this report differs as well from the narrower legal definition of
7 competence as the knowledge and skills an individual has to do a job. Rather, this report explores a
8 broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice
9 that enable physicians to assure patients, the public, and the profession that they provide safe, high
10 quality care moment to moment over the course of a professional lifetime.

11 12 SELF-ASSESSMENT & ITS LIMITATIONS

13
14 Health care institutions and the medical profession as a whole take responsibility to regulate
15 physicians through credentialing and privileging, routinely testing knowledge (maintenance of
16 certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
17 action against physicians who fail to meet expectations for competent, professional practice.
18 However, the better part of the responsibility to maintain competence rests with physicians’
19 “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
20 to maintain a level of competence commensurate with [their] clinical roles” [11].

21
22 Self-assessment has thus become “integral to many appraisal systems and has been espoused as an
23 important aspect of personal professional behavior by several regulatory bodies and those
24 developing learning outcomes for students” [12]. Undergraduate and graduate medical education
25 programs regularly use self-assessment along with third-party evaluations to ensure that trainees
26 are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

27
28 Yet how accurately physicians assess their own performance is open to question. Research to date
29 suggests that there is poor correlation between how physicians rate themselves and how others rate
30 them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and
31 trainees tend to assess their peers’ performance more accurately than they do their own; several
32 have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their
33 abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves
34 [5, 12, 17].

35
36 The available findings suggest that self-assessment involves an interplay of factors that can be
37 complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the
38 moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the
39 impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess
40 practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published
41 literature also indicates that interventions intended to enhance self-assessment may seek different
42 goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting
43 appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

44
45 Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain
46 the competence they need to provide safe, high quality care. Feedback from third parties is
47 essential—or as one researcher has observed, “The road to self-knowledge may run through other
48 people” [19]. However, physicians are often wary of assessment. They have indicated that while
49 they want feedback, they are not sure how to use information that is not congruent with their self-
50 appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or
51 exposing possible deficiencies or out of concern that soliciting feedback could adversely affect

1 their relationships with those whom they approach [20]. They may also question the accuracy and
2 credibility of the assessment process and the data it generates [21].

3
4 To be effective, feedback must be valued both by those being assessed and by those offering
5 assessment [14]. When there is tension between the stated goals of assessment and the implicit
6 culture of the health care organization or institution, assessment programs can too readily devolve
7 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
8 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
9 (“360° reviews”), for example, are generally better suited to providing feedback on communication
10 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
11 understand and use [14]. High quality feedback will come from multiple sources; be specific and
12 focus on key elements of the ability being assessed; address behaviors rather than personality or
13 personal characteristics; and “provide both positive comments to reinforce good behavior and
14 constructive comments with action items to address deficiencies” [22]. Beyond such formal
15 mechanisms, physicians should welcome and seek out informal input from colleagues. They should
16 be willing to offer timely comments to colleagues as well.

17 18 EXPERTISE & EXPERT JUDGMENT

19
20 On this broad understanding of competence, physicians’ thought processes are as important as their
21 knowledge base or technical skills. Thus, understanding competence requires understanding
22 something of the nature of expertise and processes of expert reasoning, themselves topics of
23 ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes “fast” from “slow” thinking;
24 that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
25 analytical processes that require more conscious effort [25]. Some scholars take expertise to
26 involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
27 resources acquired through experience [23]. Others argue that expertise consists in using “slow,”
28 effortful, analytic processes to address problems [23]. A more integrative view argues that
29 expertise resides in being able to transition between intuitive and analytical processes as
30 circumstances require. On this account, experts use automatic resources to free up cognitive
31 capacity so that they maintain awareness of the environment (“situational awareness”) and can
32 determine when to shift to effortful processes [23].

33
34 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
35 automatic resources and to transition appropriately to a greater reliance on effortful processes when
36 needed” [23], a practice described as “slowing down.” Knowing when to slow down and be
37 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To
38 respond to the unexpected events that often arise in a clinical situation, the physician must
39 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
40 transition into a more effortful state [24]. This can happen, for example, when a surgeon confronts
41 an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
42 serves as a critical marker for intraoperative surgical judgment [23].

43 44 INFLUENCES ON CLINICAL REASONING

45
46 Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education,
47 training, and experiences that provide tools with which to shape their clinical reasoning. Every
48 physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
49 differ from the analytical and investigative processes of their colleagues in innumerable ways.
50 When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all

1 physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics
2 and habits of perception, and succumbing to overconfidence.

3 4 *Heuristics*

5
6 Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While
7 heuristics can be useful tools to help physicians identify and categorize relevant information, these
8 time-saving devices can also derail decision making. For example, a physician may mistakenly
9 assume that “something that seems similar to other things in a certain category is itself a member of
10 that category” (the representative heuristic) [27], and fail to diagnose a serious health problem.
11 Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that
12 the physician proceeds to discount as stress or intoxication once the physician learns that the
13 patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may
14 miscalculate the likelihood of a disease or injury occurring by placing too much weight “on
15 examples of things that come to mind easily, . . . because they are easily remembered or recently
16 encountered” (the availability heuristic) [27]. For example, amidst heavy media coverage of an
17 outbreak of highly infectious disease thousands of miles away in a remote part of the world, a
18 physician seeing a patient with symptoms of what is actually a more commonplace illness may
19 misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

20
21 Clinical reasoning can be derailed by other common cognitive missteps as well. These can include
22 misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to
23 remember information transferred at the beginning (or end) of an exchange but not information
24 transferred in the middle (primary or recency bias) [25, 27, 29].

25 26 *Habits of Perception*

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

41
42 No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look
43 beyond categories and assumptions to investigate openly the health issues experienced by the
44 patient. Although all human beings exhibit both conscious and unconscious habits of perception,
45 physicians must remain vigilant in not allowing preconceived or unexamined assumptions to
46 influence their medical practice.

47 48 *Overconfidence*

49
50 Finally, another obstacle to strong clinical reasoning that physicians may encounter is
51 overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying

1 the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in
2 fact, their peers have identified areas for improvement [29]. Overconfidence in one's abilities can
3 lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the
4 advice of others, or not acknowledging one's limits [27, 29].

5
6 To avoid falling into such traps, physicians must recognize that many factors can and will influence
7 their clinical decisions [27]. They need to be aware of the information they do and do not have and
8 they need to acknowledge that many factors can and will influence their judgment. They should
9 keep in mind the likelihood of diseases and conditions and take the time to distinguish information
10 that is truly essential to sound clinical judgment from the wealth of possibly relevant information
11 available about a patient. They should consider reasons their decisions may be wrong and seek
12 alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should
13 be sensitive to the ways in which assumptions may color their reasoning and not allow expectations
14 to govern their interactions with patients.

15
16 Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming
17 aware of areas in which their skills are not at their strongest and seeking additional education or
18 consulting with colleagues, physicians can enhance their practice and best serve their patients.

19 20 FROM SELF-ASSESSMENT TO SELF-AWARENESS

21
22 Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally
23 conceived has significant shortcomings, several scholars have argued that a different understanding
24 of self-assessment is needed, along with a different conceptualization of its role in a self-regulating
25 profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one's
26 weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit
27 practice in areas in which one has limited competence, to help set appropriate learning goals, and to
28 identify areas that "should be accepted as forever outside one's scope of competent practice" [31].
29 Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence"
30 and to "set appropriately challenging learning goals" that push the boundaries of the physician's
31 knowledge [31].

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

40
41 Expert practitioners rely on pattern recognition and other automatic resources to be able to think
42 and act intuitively. As noted above, an important component of expert judgment is transitioning
43 effectively from automatic modes of thinking to more effortful modes as the situation requires.
44 Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts
45 physicians when they need to direct additional cognitive resources to the immediate task. For
46 example, among surgeons, knowing when to "slow down" during a procedure is critical to
47 competent professional performance, whether that means actually stopping the procedure,
48 withdrawing attention from the surrounding environment to focus more intently on the task at hand,
49 or removing distractions from the operating environment [24].

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

8
9 A key aspect of competence is demonstrating situation-specific awareness in the moment of being
10 at the boundaries of one’s knowledge and responding accordingly [32]. Slowing down, looking
11 things up, consulting a colleague, or deferring from taking on a case can all be appropriate
12 responses when physicians’ self-awareness tells them they are at the limits of their abilities. The
13 capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of
14 competence broadly understood:

15
16 Safe practice in a health professional’s day-to-day performance requires an awareness of when
17 one lacks the specific knowledge or skill to make a good decision regarding a particular patient
18 This decision making in context is importantly different from being able to accurately rate
19 one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that
20 self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
21 self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and
22 continuously monitoring one’s ability to effectively solve the current problem [31].

23
24 Self-aware physicians discern when they are no longer comfortable handling a particular type of
25 case and know when they need to obtain more information or need additional resources to
26 supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—
27 the death of a loved one or other family crisis, or the reorganization of their practice, for example—
28 may be affecting their ability to provide care appropriately at a given time. They recognize when
29 they should ask themselves whether they should postpone care, arrange to have a colleague provide
30 care, or otherwise find ways to protect the patient’s well-being.

31 MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

32
33
34 For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their
35 professional careers. This ideal holds not just over the course of a sustained clinical practice, but
36 equally when physicians re-enter practice after a hiatus, transition from active patient care to roles
37 as educators or administrators, or take on other functions in health care. Self-assessment and self-
38 awareness are central to achieving that goal.

39
40 A variety of strategies are available to physicians to support effective self-assessment and help
41 physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
42 day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
43 the form of written descriptions, audio or video recording, or photos of encounters with patients
44 that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
45 improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
46 standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

47
48 As noted above, to be effective, self-assessment must be joined with input from others. Well-
49 designed multi-source feedback can be useful in this regard, particularly for providing information
50 about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
51 response that elicits feedback about how well one maintains trust and professional relationships

1 with patients, one's communication and teamwork skills, and accessibility offers a valid, reliable
2 tool that can have practical value in helping to correct poor behavior and, just as important,
3 consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
4 feedback will not have the rigor of a validated tool but can accomplish similar ends.

5
6 Reflective practice, that is, the habit of using critical reflection to learn from experience, is
7 essential to developing and maintaining competence across a physician's practice lifetime [37]. It
8 enables physicians to "integrate personal beliefs, attitudes, and values in the context of professional
9 culture," and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
10 assessed, and that it can be developed, but also that the habit can be lost over time with increasing
11 years in practice [37].

12
13 "Mindful practice," that is, being fully present in everyday experience and aware of one's own
14 mental processes (including those that cloud decision making) [38], sustains the attitudes and skills
15 that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
16 behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined
17 negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can
18 be self-taught, but for most it is most effectively learned in relationship with a mentor or guide.
19 Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness.
20 Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of
21 encounters with patients, or seeking insight from critical incident reports [38].

22
23 "Exemplary physicians," one scholar notes, "seem to have a capacity for self-critical reflection that
24 pervades all aspects of practice, including being present with the patient, solving problems,
25 eliciting and transmitting information, making evidence-based decisions, performing technical
26 skills, and defining their own values" [38].

27 28 RECOMMENDATION

29
30 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
31 remainder of this report be filed:

32
33 The expectation that physicians will provide competent care is central to medicine. It
34 undergirds professional autonomy and the privilege of self-regulation granted by society. To
35 this end, medical schools, residency and fellowship programs, specialty boards, and other
36 health care organizations regularly assess physicians' technical knowledge and skills.

37
38 However, as an ethical responsibility competence encompasses more than medical knowledge
39 and skill. It requires physicians to understand that as a practical matter in the care of actual
40 patients, competence is fluid and dependent on context. Each phase of a medical career, from
41 medical school through retirement, carries its own implications for what a physician should
42 know and be able to do to practice safely and to maintain effective relationships with patients
43 and with colleagues. Physicians at all stages of their professional lives need to be able to
44 recognize when they are and when they are not able to provide appropriate care for the patient
45 in front of them or the patients in their practice as a whole.

46
47 To fulfill the ethical responsibility of competence, individual physicians and physicians in
48 training should:

- 49
50 (a) Exercise continuous self-awareness and self-observation;

- 1 (b) Recognize that different points of transition in professional life can make different
2 demands on competence;
3
4 (c) Take advantage of well-designed tools for self-assessment appropriate to their practice
5 settings and patient populations;
6
7 (d) Seek feedback from peers and others;
8
9 (e) Be attentive to environmental and other factors that may compromise their ability to bring
10 appropriate skills to the care of individual patients and act in the patient's best interest.
11
12 Medicine as a profession should continue to refine mechanisms for assessing knowledge and
13 skill and should develop meaningful opportunities for physicians and physicians in training to
14 hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than \$500.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-17

Subject: Ethical Physician Conduct in the Media

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr, MD, Chair)

1 Directive D-140.957 (1), “Ethical Physician Conduct in the Media,” adopted at the 2015 HOD
2 Annual Meeting, calls for a report on the professional ethical obligations of physicians in the
3 media. The following analysis by the Council on Ethical and Judicial Affairs (CEJA) addresses
4 ethics concerns in this area and offers guidance for physicians who participate in the media.
5

6 PHYSICIANS IN THE PUBLIC SPHERE 7

8 Physicians’ knowledge is not confined to the clinical setting. Physicians have well-recognized
9 responsibilities to use their knowledge and skills for the benefit of the community as a whole,
10 whether it is by assisting a state health agency in identifying and tracing infectious disease during
11 an epidemic, advocating for improved health care resources to lessen health disparities, or
12 promoting behaviors that improve the health of communities [1]. Stepping into the media
13 environment can serve as an extension of this public function.
14

15 However, the expectations held of physicians as members of the medical profession and of persons
16 in the media are not always compatible. Participation in the media can have unintended
17 consequences for the physician and the medical profession. Information in the public sphere can be
18 sensationalized, misrepresented, or patently falsified, which can have potentially serious
19 consequences if the benefits and drawbacks of medical advice are not appropriately conveyed [2].
20 Furthermore, physician recommendations may not always reflect the standard of care [3, 4].
21

22 A CONTINUUM OF ROLES 23

24 Physicians can engage the media in a number of roles. For example, they can serve as conveyors of
25 information or advocates on behalf of public agencies or institutions; as expert consultants on
26 medical science and practice; as commentators on health-related issues of interest to the public; or
27 as journalists covering medicine-related stories. Imagine the following:
28

29 *Dr. A is head of a health care agency in the federal government. A physician with two decades*
30 *of public service experience, she is directly responsible for guiding the legislative goals of the*
31 *agency and is supported by a staff of thousands of federal employees. Dr. A often gives*
32 *statements to the press about matters under the agency’s jurisdiction, and has, from time to*

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 *time, participated in press conferences to speak on urgent matters of public health or to make*
2 *statements intended to garner greater legislative attention and support.*

3
4 *Dr. B works at an academic medical center. He is frequently approached by media outlets to*
5 *comment on recent breakthroughs in medicine or topical issues in medicine and public health*
6 *that are making their way through the news cycle. Dr. B also regularly contributes opinion*
7 *pieces about medicine and health care policy to news outlets.*

8
9 *Dr. C is a physician whose work has been lauded by practitioners, academics, and celebrities*
10 *alike. Recently, she has launched a daytime television program in which she discusses popular*
11 *subjects related to medicine, public health, and a general assortment of topics regarding*
12 *health and well-being. Dr. C maintains a practice where she sees patients, but the majority of*
13 *her time is now spent producing and appearing on her television show.*

14
15 As a public official, Dr. A uses the media to further a political agenda regarding the health and
16 well-being of the American public, an agenda she has been tasked with upholding and protecting.
17 For her, the media is a vehicle to address the needs and concerns of the public, and to keep the
18 policy goals of her agency at the forefront of awareness among government and private actors
19 integral to the provision of medical care.

20
21 Dr. B is first and foremost an academic physician whose interactions with the media serve a more
22 consultative function. He generally offers his insight only when approached by the media, although
23 he may occasionally use his training and experience proactively to shed light on topics when he
24 feels the public may derive some educational benefit.

25
26 In contrast, Dr. C holds herself out to a national audience as a commentator on any number of
27 subjects falling under the general categories of medicine, health, and wellness—topics that are at
28 least in part developed by producers and pitched for their ability to boost ratings and increase
29 viewership. Her audience may or may not know the specifics of her training and experience,
30 although she uses her medical degree as a symbol of authority and credibility. Moreover, as a
31 media celebrity, the recommendations she makes on air may be especially persuasive [4].

32
33 Whatever role physicians adopt when they participate in the media is very different from that of a
34 clinical practitioner interacting with individual patients. Whether the medium is print, digital, or
35 social, physicians who take part in the media marketplace engage in what is fundamentally a
36 unidirectional relationship with the members of a vast audience who may regard themselves as
37 patients, but whom the physician will never encounter in person. When a video clip ends or a
38 reporter stops asking questions, the contact media physicians have with the audience ends. The
39 hundreds, if not millions, of individuals who have watched, listened, or read have no opportunity to
40 provide details about their unique medical histories, probe for more guidance about a treatment that
41 was discussed, or report back to the physician about what effect, if any, the physician's advice has
42 had.

43 44 FIDELITY, TRUST, AND DIVIDED LOYALTIES

45
46 For physicians in the media, then, navigating successfully among the potentially overlapping roles
47 of clinician, expert consultant, journalist, or (for some) media personality poses challenges. Being
48 clear about what role(s) they are playing at any given time is crucial [3]. So is being aware of how
49 media content they create or the media presence they have blurs the lines of medicine, journalism,
50 and entertainment [3, 5].

1 For a physician who pursues a distinct career as a singer, a dancer, or a cook on the line in a
2 restaurant kitchen, the new role is entirely different than that of a physician [6]. But when a media
3 career involves depending on the inherent authority of their MD or DO degree rather than their
4 training and skills, physicians in the media are taking advantage of the credibility and prestige
5 bestowed by the public and the media on members of the medical profession [6, 7]. It may never
6 occur to a cancer patient watching a physician on television that “someone highly credentialed
7 might mix critical medical advice with a touch of ‘shock and awe’” even when such behavior
8 might be condemned by other physicians and the medical profession as a whole [7].
9

10 Media entities themselves can have diverging interests and goals—winning a Pulitzer or an Emmy
11 for excellence may compete with attracting advertising dollars, viewership, and ratings. Where the
12 latter are the hallmarks of success, the qualifications of physicians who are media personalities, and
13 the quality of the information they are disseminating, can be secondary for producers and audiences
14 [6]. When there is temptation, or pressure, to attract an audience, it can be challenging for
15 physicians to navigate the overlapping roles of health care professional and media personality, and
16 to hold steady to the norms and values of medicine [7].
17

18 *Trustworthiness and Authoritativeness*

19

20 By using their medical expertise to reach out to an audience that is local, national, or even global in
21 scale, physicians in the media carry with them heightened expectations as trusted resources,
22 advisors, and representatives of the medical profession. Thus, like physicians in other roles that do
23 not involve directly providing care for patients in clinical settings, physicians in the media should
24 be expected to uphold the values and norms of medicine as a priority [8].
25

26 With respect to the recommendations or clinical perspectives a physician contributes to a media
27 forum, such information must be acquired through practical clinical experience or supported by
28 rigorous scientific research that has been carefully vetted within the peer-reviewed literature and
29 presented accurately in the appropriate context [9, 10]. Physicians should likewise be transparent
30 about the limitations of their knowledge or experience in a given area.
31

32 A message that is inaccurate, questionable, or false, may still be perceived as authoritative because
33 it comes from a physician [2, 7]. Efforts to correct or recant misinformation from the public forum
34 may prove futile. One contemporary example of this is the still pervasive but false public
35 perception that childhood vaccines are linked to autism, despite the fact that this perception rests on
36 a long-since discredited physician’s publication and there is overwhelming scientific consensus that
37 no such relationship exists [11]. Material that is of poor quality and that does not meet expected
38 standards of scientific rigor can mislead individuals who do not question the content of the
39 message, while the promotion of such subpar work can erode the public’s trust in the larger
40 medical community [7, 12].
41

42 *Maintaining Privacy in the Public Eye*

43

44 Physicians working in the media must be cognizant of their work’s impact on patient anonymity,
45 the process of patient consent (concerns of inadvertent coercion), and the potential to exploit
46 patients. They must also make decisions about whether they will present the outcome of a patient
47 case as a fictional representation or as a story of true events [2, 13]. While journalism requires strict
48 adherence to the facts and details of a story, physicians asked to recount a procedure or speak to
49 media about a particular case have a responsibility to obscure or alter details that would reveal a
50 patient’s identity unless the patient freely gave informed consent [13]. Physicians must also remain
51 sensitive to how a story will affect patients under their care, and avoid situations where breaches of

1 privacy and confidentiality may occur [13, 14, 15]. In the media, physicians may at times need to
2 emulate storytellers rather than journalists [13].

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

14
15 Moreover, physicians may be enticed into offering professional opinion that is outside their
16 individual area of expertise. Physicians who offer expert testimony in court are expected to testify
17 "only in areas in which they have appropriate training and recent, substantive experience and
18 knowledge" [16]. The same expectations should apply to physicians who offer public commentary
19 on health-related matters.

20 21 CONFLICTS AND DISCLOSURES

22
23 Competing interests are a fact of life for everyone, not only physicians in the media [17]. But as
24 individuals in positions of public trust, media physicians should be especially sensitive to possible
25 conflicts of interest. Even when there is no actual conflict, the appearance of influence or bias can
26 compromise trust in the physician and the broader profession, with downstream consequences for
27 patients and the public.

28
29 Taking steps to ensure transparency, independence, and accountability allows media consumers to
30 make informed judgments about the comments or recommendations offered by physicians who are
31 active in the media. Disclosing conflicts of interest is an essential first step [18, 19, 20]. Direct,
32 substantial financial relationships that may influence a physician's judgment, such as research
33 funding, remuneration for advisory services or speaking engagements, or equity interests in
34 featured products or services, should always be disclosed.

35
36 Nonfinancial relationships can also affect judgment and should be disclosed; for example, when a
37 media physician has fiduciary responsibilities to a commercial entity that has an interest in the
38 subject matter. Personal, political, ideological, or intellectual interests can also influence
39 professional judgment in particular situations and media physicians should be prepared to disclose
40 such interests [17, 21, 22].

41
42 Disclosure alone is not sufficient, however, and may have the perverse effect of inspiring false
43 confidence on the part of media consumers and even discourage the media physician from
44 rigorously ensuring that he or she is offering objective, unbiased information [23]. In some
45 circumstances, the threat of actual or perceived conflicts of interest may be so great that the only
46 way forward is for the physician to avoid the potential situation altogether.

47
48 Instituting measures to promote independent content is a further important step. For example,
49 editorial review of proposed content and presentation can help identify possible bias or the
50 appearance of bias or catch elements that media consumers might be expected to misinterpret.
51 Prohibiting physicians who have clear, unresolved competing interests from being media

1 spokespersons on issues that involve those interests can likewise help ensure independence [24].
2 Making explicit to viewers the measures taken to address and mitigate the influence of conflicts of
3 interest will hold media physicians accountable to their peers and the public for exercising sound
4 professional judgment.

5
6 CONCLUSION

7
8 As trusted members of the community who regularly communicate with the public about health
9 and wellness, physicians have a responsibility to consider their ethical obligations to their patients,
10 the public, and the medical profession. In an increasingly technologically adept media marketplace
11 where the context and delivery of messages are shaped by any number of social and financial
12 forces, physicians must carefully delineate who they are and how they want to be perceived.
13 Equally important, physicians should give thought to how they want to frame and support their
14 messages, and how those messages should be consumed and utilized.

15
16 RECOMMENDATION

17
18 In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the
19 following be adopted in lieu of D-140.957(1) and the remainder of this report be filed:
20

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

26
27 Physicians involved in the media environment should be aware of their ethical obligations to
28 patients, the public, and the medical profession; and that their conduct can affect their medical
29 colleagues, other health care professionals, as well as institutions with which they are affiliated.
30 They should also recognize that members of the audience might not understand the
31 unidirectional nature of the relationship and might think of themselves as patients. Physicians
32 should:

- 33
34 (a) Always remember that they are physicians first and foremost, and must uphold the values,
35 norms, and integrity of the medical profession.
36
37 (b) Encourage audience members to seek out qualified physicians to address the unique
38 questions and concerns they have about their respective care when providing general
39 medical advice.
40
41 (c) Be aware of how their medical training, qualifications, experience, and advice are being
42 used by media forums and how this information is being communicated to the viewing
43 public.
44
45 (d) Understand that as physicians, they will be taken as authorities when they engage with the
46 media and therefore should ensure that the medical information they provide is:
47
48 (i) accurate
49
50 (ii) inclusive of known risks and benefits

- 1 (iii) commensurate with their medical expertise
- 2
- 3 (iv) based on valid scientific evidence and insight gained from professional experience
- 4
- 5 (e) Confine their medical advice to their area(s) of expertise, and-should clearly distinguish the
- 6 limits of their medical knowledge where appropriate.
- 7
- 8 (f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities,
- 9 persons in the news) they have not had the opportunity to personally examine.
- 10
- 11 (g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable
- 12 information, unless given specific permission by the patient to do so.
- 13
- 14 (h) Fully disclose any conflicts of interest and avoid situations that may lead to potential
- 15 conflicts.
- 16
- 17 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 3-I-17

Subject: Supporting Autonomy for Patients with Differences of Sex Development (DSD)
(Resolution 3-A-16)

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr, MD, Chair)

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

5
6 That our AMA affirm that medically unnecessary surgeries in individuals born with
7 differences of sex development are unethical and should be avoided until the patient
8 can actively participate in decision-making.
9

10 Testimony regarding BOT 7-I-16 expressed concern about possible unintended consequences and
11 lack of expert insight into the medical complexities in treating differences of sex development in
12 pediatric patients. The Council on Ethical and Judicial Affairs was asked to prepare a report
13 providing ethics guidance in this area.
14

15 BACKGROUND

16
17 The term “differences of sex development” (DSD), now preferred over “disorders of sex
18 development,” is used to refer to congenital conditions “in which development of chromosomal,
19 gonadal, or anatomic sex is atypical,” broadly encompassing five main groups [1]:
20

- 21 • 46,XX, classical congenital adrenal hyperplasia (CAH);
- 22 • 46,XY, a heterogenous set of conditions that includes abnormal androgen steroidogenesis
23 and 5 α reductase deficiency;
- 24 • varieties of sex chromosome mosaicism, such as mixed gonadal dysgenesis (45,X/46,XY
25 DSD);
- 26 • ovo-testicular DSD in which patients present with both ovarian and testicular tissues and
27 abnormally differentiated genital structures; and
- 28 • “nonhormonal/nonchromosomal” DSD, represented by abnormal genitalia.
29

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

1 rare cases, laparotomy or laparoscopy [4]. Some 60 percent of affected children are now diagnosed
2 prenatally [4].

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

9
10 Early diagnosis is essential to identify and intervene in life-threatening conditions. Historically,
11 treatment for DSD also gave high priority to medically assigning gender in a newborn with
12 ambiguous genitalia under what became known as an “optimal gender policy” intended to
13 “facilitate stable gender identity and appropriate gender role behavior” [5]. This approach
14 recommended early surgery to match genitalia to assigned gender, on the rationale that uncertain
15 gender is distressing for the family, may adversely affect the child’s mental health, and can lead to
16 stigmatization [4,5,6]. This view has been increasingly challenged [5,7]. DSD communities and a
17 growing number of health care professionals have condemned such genital “normalizing,” arguing
18 that except in the rare cases in which DSD presents as life-threatening anomalies, genital
19 modification should be postponed until the patient can meaningfully participate in decision making
20 [5,8,9,10].

21
22 In 2006, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) observed
23 that “[m]uch of the clinical challenge intrinsic to pediatric urology rests in the need to discriminate
24 between children at risk for severe long-term complications and requiring intervention and the
25 larger group who are not. The report noted the lack of sufficient data to guide decisions about
26 gender assignment and absence of clear guidelines for clinical practice, particularly in light of
27 concerns about the irreversibility of surgical intervention and possible sensory damage to the
28 genitalia [11]. The NIDDK cited the lack of “systematic outcome data about sexual function in
29 individuals with disorders of sexual differentiation [sic]” and of data “pertaining to the association
30 of sexual function with genital appearance and types of genital surgery.” It concluded that “it
31 is unclear whether gender identity requires gender-consistent genital appearance” and urged
32 prospective studies of gender identity, reproductive function, and quality of life for patients with
33 DSD [11].

34
35 A decade later, outcomes data remain limited. A small study carried out in 2011–2012 among
36 medical students in Zurich found that how physicians discussed treatment for a child with DSD
37 influenced the choice for or against surgery [12]. Participants watched brief counseling videos that
38 described DSD either as a condition that is static, has an inherent psychosocial component, and
39 requires treatment, and for which predetermined treatment regimens focus on biological function,
40 or as a dynamic disorder characterized by context-dependent impairment for which coping
41 strategies should be fostered, with treatment geared to the individual’s interests and capabilities.
42 Sixty-six percent of participants who viewed the medicalized video said they would choose early
43 surgery for their child, compared to 23 percent of those who viewed the demedicalized video. In a
44 systematic review of follow-up of psychological outcomes of intervention for patients with DSD
45 published in 2015, Brazilian researchers found a lack of prospective long-term evaluations of
46 psychological outcomes of sex assignment surgery [13]. They noted concerns about the quality of
47 published studies, citing variable sample size, inconsistent methodologies, and poorly defined
48 outcome measures.

1 NEW PARADIGMS FOR TREATMENT

2
3 In addition to the NIDDK report questioning the “optimal gender” policy, in 2006 both the Intersex
4 Society of North America (ISNA) and the International Consensus Conference on Intersex released
5 guidelines on the management of DSD that urged a more conservative approach [1,14]. ISNA
6 guidelines note that gender assignment “is a social and legal process *not requiring medical or*
7 *surgical intervention*” (original emphasis) [ISNA 2006]. The guidelines recommend delaying
8 elective surgical and hormonal treatments until the patient can participate in decision making and
9 caution that health care professionals must distinguish between offering medically needed
10 treatment to benefit the child and offering treatment to allay parental anxiety. Like the ISNA, the
11 consensus statement of the International Consensus Conference on Intersex recommended
12 deferring elective interventions and similarly urged that care be provided by a multidisciplinary
13 team. In 2016 the Global DSD Update Consortium reviewed developments over the preceding
14 decade, noting particularly the important role that peer support can play in helping parents, and
15 children, make informed decisions about elective treatment [15].
16

17 In its 2017 report on the rights of children in biomedicine, the Bioethics Committee of the Council
18 of Europe observed that, based its review of on available scientific evidence, only three
19 interventions meet criteria of being “medically necessary”: “(1) administration of endocrine
20 treatment to prevent fatal salt-loss in some infants, (2) early removal of streak gonads in children
21 with gonadal dysgenesis, and (3) surgery in rare cases to allow exstrophic conditions in which
22 organs protrude from the abdominal wall or impair excretion” [16]. However, these
23 recommendations remain controversial and there is not yet consensus in the medical community.
24 Recent interviews carried out by Human Rights Watch among individuals with DSD examine
25 patient experience and underscore the value of organizing dedicated multidisciplinary care teams
26 [17].
27

28 In educational material for parents, the American Academy of Pediatrics likewise stresses
29 multidisciplinary care and notes that, if not medically necessary, “any irreversible procedure can be
30 postponed until the child is old enough to agree to the procedure (e.g., genital surgery)” [18].
31

32 CURRENT AMA POLICY

33
34 Current AMA policy does not address treatment for patients with DSD directly. Rather, a limited
35 number of ethics and House policies speak to decisions for minors more broadly, as well as to
36 issues pertaining to gender identity, sexual orientation, transgender health, and discrimination
37 toward sexual minority communities:
38

- 39 • [Opinion 2.2.1](#), “Pediatric Decision Making,” encourages involving minor patients in
40 decision making at a developmentally appropriate level, including decisions that involve
41 life-sustaining interventions, and recommends that physicians work with parents or
42 guardians to simplify complex treatment regimens for children with chronic health
43 conditions.
44
- 45 • [Opinion 2.2.4](#), “Treatment Decisions for Seriously Ill Newborns,” articulates the
46 considerations that must be taken into account when addressing emotionally and ethically
47 challenging cases involving newborns, including: the medical needs of the child; the
48 interests, needs, and resources of the family; available treatment options; and respect for
49 the child’s right to an “open future.” It calls on physicians to inform parents about
50 available therapeutic options and the nature of those options and to discuss the child’s
51 expected prognosis with and without intervention.

- 1 • [Opinion 2.2.5](#), “Genetic Testing of Children,” identifies conditions under which physicians
2 may ethically offer genetic testing for minor patients. It observes that testing implicates
3 important concerns about the autonomy and best interests of the minor patient and holds
4 that medical decisions made on behalf of a child should not abrogate the opportunity to
5 choose to know his or her genetic status as an adult.
6

7 DECISIONS FOR PEDIATRIC PATIENTS

8

9 Parents (or guardians) are granted the authority to make health care decisions for their minor
10 children when the child lacks the ability to act independently or does not have the capacity to make
11 medical decisions [19]. Parents are deemed to be in a better position than others to understand their
12 child’s unique needs and interests, as well as their family’s, and thus to be able to make appropriate
13 decisions regarding their child’s health care. Historically, the best interest standard has
14 predominated as the appropriate decision-making standard for medical decisions for minors.
15 Current consensus rests on a more nuanced view that encompasses not only the patient’s medical
16 interests, but psychosocial and familial concerns as well [19].
17

18 The “harm principle” has been suggested as a further refinement on the decision-making standard,
19 requiring not only that decision makers consider the patient’s best interests, broadly understood,
20 but also that a threshold of harm be identified, below which decisions should not be tolerated [19].
21 Parents (or guardians) are also recognized to have a responsibility to foster their children’s
22 autonomy and moral growth, a responsibility clinicians share. Providing information in a
23 developmentally appropriate way that respects the minor patient’s cognitive ability, engaging the
24 child in decision making to the extent possible, and seeking the child’s assent to proposed
25 interventions helps to fulfill that responsibility [19].
26

27 With respect to DSD specifically, suggested broad principles to guide decisions about elective
28 interventions have been suggested. Proposals emphasize the need to balance leaving future options
29 open [9] and upholding the child’s right to participate in decision making [5] with respect for
30 parents’ wishes and family relationships. Likewise, they concur that decisions for patients with
31 DSD should focus on promoting the well-being of the child and future adult [5], including
32 minimizing physical and psychosocial risks to the child, preserving potential for fertility, and
33 preserving capacity for satisfying sexual relations [9].
34

35 In cases of DSD, decisions about a child’s best interests and appropriate interventions involve
36 sensitive issues of sex, gender, and sexuality, and interventions that may be irreversible. Parents are
37 often concerned about the future well-being of their child with regard to self-identity, relationships,
38 and reproductive capacity [8]. Because of these concerns, they may be quick to want to establish
39 sex and gender identity for their child in order to promote “normalcy” and reduce stigmatization.
40 Moreover, when physicians perceive early intervention to be urgently needed or wholly beneficial,
41 they may not fully recognize that there is a decision to be made, or the complexity of that decision
42 for the family and patient.
43

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

1 action was dismissed on appeal by the US Court of Appeals for the Fourth Circuit (in January
2 2015) [20], the lower court had denied the defendants' request for dismissal on the grounds that the
3 defendants may have violated MC's constitutional right to procreate [21]. In July 2017, the
4 Medical University of South Carolina denied all claims and liability, but agreed to a settlement
5 with the family [22].

6 7 RECOMMENDATION

8
9 The Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, "Pediatric Decision
10 Making," be amended as follows in lieu of Resolution 3-A-16 and the remainder of this report be
11 filed:

12
13 Unlike health care decisions for most adult patients, decisions for pediatric patients usually
14 involve a three-way relationship among the minor patient, the patient's parents (or guardian),
15 and the physician. Although children who are emancipated may consent to care on their own
16 behalf, in general, children below the age of majority are not considered to have the capacity to
17 make health care decisions on their own. Rather, parents or guardians are expected, and
18 authorized, to provide or decline permission for treatment for minor patients. Nonetheless,
19 respect and shared decision making remain important in the context of decisions for minors,
20 ~~and p~~ Physicians have a responsibility to support the child's emerging autonomy and should
21 engage minor patients in making decisions about their own care to the greatest extent possible,
22 ~~including decisions about life-sustaining treatment.~~

23
24 Decisions made for pediatric patients should seek to foster the well-being of
25 children patients and the adults they will become. Physicians should provide information and
26 other resources to support parents or guardians in making decisions about their child's care and
27 should individualize treatment to promote the child's best interest, which is determined by
28 weighing many factors, including effectiveness of available appropriate medical therapies and
29 the needs and interests of the patient and the family as the source of support and care for the
30 patient.

31
32 Parents or guardians must also assess whether the decision made for a minor patient will
33 abrogate a choice the future individual would want to make for him- or herself. Except when
34 immediate treatment is medically necessary to preserve life or avert serious and irreversible
35 harm, physicians should support parents' efforts to make decisions that do not undermine the
36 child's right to an "open future." When there is ~~legitimate inability to reach~~ no consensus in the
37 field about what is in the best interest of the child, the wishes of the parents/guardian should
38 generally receive preference.

39
40 For health care decisions involving minor patients, physicians should:

- 41
42 (a) Involve all patients in decision making at a developmentally appropriate level.
43
44 (b) ~~Base recommendations for treatment on the likely benefit to the patient, taking into~~
45 ~~account the effectiveness of treatment, risks of additional suffering with and without~~
46 ~~treatment, available alternatives, and overall prognosis~~ as indicated by the best available
47 scientific evidence. Where there are questions about the efficacy or long-term impact of
48 treatment alternatives, physicians should encourage ongoing collection of data to help
49 clarify the value to patients of different approaches to care.

- 1 (c) For patients capable of assent, truthfully explain the medical condition, its clinical
2 implications, and the treatment plan in a manner that takes into account the child's
3 cognitive and emotional maturity and social circumstances for patients capable of assent.
4
- 5 (d) Provide a supportive environment to promote the well-being of both the patient and the
6 family and encourage parents to discuss their child's health status with the patient. Offer to
7 facilitate the parent-child conversation for reluctant parents.
8
- 9 (e) Recognize that ~~for~~ certain medical conditions, such as those involving
10 HIV/AIDS, ~~or~~ inherited conditions, or developmental anomalies, may involve highly
11 sensitive information. ~~Disclosing the child's health status may also reveal health~~
12 information about biological relatives, or disrupt relationships within the family, or lead to
13 stigma or discrimination. Physicians should offer education and support to help minimize
14 the psychosocial impact of such conditions for the child and the family.
15
- 16 (f) Work with parents/guardians to simplify complex treatment regimens whenever possible
17 and educate parents in ways to avoid behaviors that put the child or others at risk.
18
- 19 (g) ~~Ensure that w~~When decisions involve life-sustaining interventions, ensure that patients
20 have opportunity to be involved in keeping with their ability to understand decisions and
21 their desire to participate. Physicians should ensure that the patient and parents/guardian
22 understand the patient's diagnosis, both with and without treatment. Physicians should
23 discuss with the patient and parents/guardian the option of initiating an intervention with
24 the intention of evaluating its clinical effectiveness after a specified amount of time to
25 determine if it has led to improvement. Confirm that if the intervention has not achieved
26 agreed-on goals it may be withdrawn.
27
- 28 (h) Respect the decisions of the patient and parents/guardian when it is not clear whether a
29 specific intervention promotes the patient's best interests.
30
- 31 (i) Seek consultation with an ethics committee or other institutional resource when:
32
- 33 (i) there is a reversible life-threatening condition and the patient (if capable) or
34 parents/guardian refuse treatment the physician believes is clearly in the patient's best
35 interest; or
36
- 37 (ii) there is disagreement about what the patient's best interests are. Physicians should turn
38 to the courts to resolve disagreements only as a last resort.
39
- 40 (j) Provide compassionate and humane care to all pediatric patients, including patients who
41 forgo or discontinue life-sustaining interventions.

(Modify Current HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-I-17

Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr, MD, Chair)

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

4
5 conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to
6 include any impact on access to services of consolidation in secular hospital systems and
7 religiously-affiliated hospital systems.

8
9 The resolution on which this directive is based discussed the conflicts present in decision-making
10 for health care professionals employed by religiously affiliated institutions. Given that the presence
11 of religiously affiliated hospitals continues to grow, the resolution encouraged our AMA to conduct
12 a study of access to care in secular hospitals and religiously affiliated hospitals to include any
13 impact on access to services in the consolidation of systems.

14
15 **RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS**

16
17 The concept of the hospital as a facility providing inpatient care for the sick originated with the
18 Catholic Church, with the original and enduring dual mission of healing the body and promoting
19 spiritual well-being [1]. The mission of today’s Catholic Health Association remains focused on
20 the needs of those who are “poor, underserved, and most vulnerable” [2]. Although hospitals
21 established by Protestant denominations and Jewish-identified facilities remain important segments
22 of U.S. health care, Catholic facilities predominate among religiously affiliated institutions—U.S.
23 Catholic Health Care is the largest nonprofit care provider in the country [2].

24
25 Since the 1990s, mergers between secular and religiously affiliated hospitals and health care
26 institutions have been reshaping the landscape of health care in the United States, for both patients
27 and physicians. Driven by economic considerations and changes in health policy, notably in recent
28 years, emphasis on accountable care organizations and bundled payments [1,3], mergers have
29 enabled facilities in some cases simply to survive and in others to thrive within their communities.
30 Consolidation has enabled hospitals to control a greater share of their local markets and to
31 negotiate effectively with insurers [4].

32
33 Religiously affiliated hospitals and facilities benefit from the tax-exempt status of the religious
34 institutions they represent and from other tax subsidies that derive from their mission to serve the
35 poor and provide charitable care [5]. Although the majority of religiously affiliated hospitals
36 remain nonprofit, the number of for-profit hospitals affiliated with religious institutions increased
37 by 22 percent between 2001 and 2016 [6]. Religiously affiliated health care facilities—which

1 encompass clinics, hospitals, and long-term care facilities—are also important employers.
 2 According to the Catholic Health Association, as of 2017 member facilities employed more than
 3 500,000 full-time and 200,000 part time staff [2].
 4

5 In some communities, religiously affiliated health care institutions may be the only providers [6]—
 6 as of 2015, 132 of the nation’s approximately 1,300 critical access hospitals were members of U.S.
 7 Catholic Health Care [2]. In some areas, more than 40 percent of short-term, acute care beds are in
 8 Catholic facilities [6]. Nationwide, one in every six patients now receives care in a Catholic
 9 hospital [2].
 10

11 THE DILEMMA OF MERGERS
 12

13 The consolidation of a religiously affiliated institution with a secular health care facility raises
 14 challenges for all stakeholders—the facilities, their communities, their patients, and the physicians
 15 and other professionals who provide care. All religiously affiliated institutions seek to remain
 16 faithful to their defining mission and values, which can place them in tension with their secular
 17 counterparts. Catholic facilities, however, are embroiled in an increasingly public debate about the
 18 implications and effects of entering into arrangements with secular institutions as they seek to
 19 retain their identity and mission and still survive in the health care marketplace. Thus they offer a
 20 window through which to understand the ethical dimension of health care mergers.
 21

22 As the *Ethical and Religious Directives* that govern care in Catholic health care facilities observe:
 23

24 New partnerships can be opportunities to realign the local delivery system in order to provide a
 25 continuum of health care to the community; they can witness to a responsible stewardship of
 26 limited health care resources; and they can be opportunities to provide to poor and vulnerable
 27 persons a more equitable access to basic care.
 28

29 On the other hand, new partnerships can pose serious challenges to the viability of the identity
 30 of Catholic health care institutions and services, and their ability to implement these Directives
 31 in a consistent way, especially when partnerships are formed with those who do not share
 32 Catholic moral principles (§VI)[7].
 33

34 From this perspective, in the contemporary health care marketplace Catholic hospitals “are caught
 35 in an impossible bind” [1]. Like other hospitals, financial pressures drive them to consolidate with
 36 other institutions to become more economically efficient. Yet “competing in the aggressive world
 37 of the medical business industry” can put Catholic hospitals’ historical commitment to the poor at
 38 risk [1]. At the same time, gaining financial security may risk “imperceptibly compromising their
 39 traditional Catholic witness” when compromises are made with respect to *Directives* [1].
 40

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

1 From the perspective of physicians and other health care professionals affiliated with or employed
2 by the entity that results, a merger can challenge professional commitments. A merger that results
3 in loss of access to services for the community and requires physicians to follow the religious
4 guidelines embodied in the *Directives* may result in “conflict with prevailing medical standards of
5 care and ethical principles of health care professional” [15]. Physicians and other health care
6 professionals who are not members of the faith tradition may find themselves contractually
7 prohibited from providing care that is otherwise legal and, in their professional judgment, clinically
8 appropriate and ethically permissible under the norms of medical professionalism.
9

10 THE RESPONSIBILITIES OF LEADERSHIP

11
12 As challenging as mergers between secular and religiously affiliated health care facilities may be
13 for individual patients and physicians, addressing dilemmas of mission is pre-eminently a
14 responsibility of hospital leadership.
15

16 For Catholic facilities merging with secular facilities (or facilities associated with other religious
17 traditions), a touchstone is the principle of cooperation [16, 17]. The principle, it is argued, is a
18 necessity for business relationships in a pluralistic world, providing a way to address the reality
19 that, for the faithful, “it is almost impossible to bring about good without brushing up against or
20 even becoming somewhat involved in the wrongdoing of others” [16]. The principle of cooperation
21 is understood “as a *limiting principle*, to avoid cooperating in evil” (original emphasis) [17].
22

23 The essential goal is to ensure that institutional arrangements allow the facility and its staff to
24 “remain as removed as possible” from violations of the directives and “not [to] contribute anything
25 essential to make possible the wrongdoing’s occurring” [16]—e.g., essential employed staff or
26 equipment for the performance of what under the *Directives* is an immoral procedure [17]. Whether
27 services that would be otherwise prohibited by the *Directives* will or may be available through the
28 merged entity is importantly a function of how caregiving is organized in the resulting composite
29 system. The approval of the diocesan bishop is required for mergers involving facilities subject to
30 his governing authority, and the diocesan bishop has final authority for assessing whether a
31 proposed merger constitutes morally licit cooperation (§VI) [7].
32

33 Analogous discussions of the ethics of trusteeship, such as that offered by The Hastings Center,
34 offer secular insight for thinking about the responsibilities of leaders in health care institutions.
35 Trustees of not-for-profit health care organizations “regularly make decisions that affect the lives
36 and well-being of a large number of people who are relatively powerless, relatively vulnerable, and
37 in need of services or assistance” [18]. In light of the mission of such organizations, service on a
38 board of trustees entails fiduciary duties to the organization and responsibility to ensure that the
39 organization realizes the public benefits for which it enjoys tax exempt status.
40

41 Trustees are held to principles of fidelity to mission; service to patients, ensuring that the care is
42 high quality and provided “in an effective and ethically appropriate manner”; service to the
43 community the hospital serves, deploying hospital resources “in ways that enhance the health and
44 quality of life” of the community; and institutional stewardship. They have a further responsibility
45 to ensure that when there is conflict over fundamental values and principles, “all points of view are
46 heard and taken seriously, that reasonable compromise is explored, and that consensus has time to
47 form” [18].
48

49 The *Principles of Integrated Leadership for Hospitals and Health Care Systems*, developed in
50 collaboration by the American Hospital Association (AHA) and the AMA, address responsibilities
51 of hospital leadership in the context of rapidly evolving models of integrated physician-hospital

1 health care systems [19]. In addition to governance and management structure and leadership
2 development, guidance identifies “cultural adaptation” as a key element for success, observing that:

3
4 Culture is the way an organization, institution or integrated health system does business, in a
5 way that is predictable, known to all and consonant with the mission and values of the
6 organization, institution or integrated health system. The creation of a common shared culture
7 that includes an integrated set of values is important to serve as a guide to the entity and will
8 serve as a touch point to help resolve the inevitable conflicts that will arise [19].
9

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

14 15 INSIGHT FROM THE CODE OF MEDICAL ETHICS

16
17 As frontline clinicians, physicians (and other health care professionals) regularly confront the
18 effects on patients’ lives and well-being of the institutional arrangements through which care is
19 delivered. They have a responsibility to advocate for the resources patients need, as well as to be
20 responsible stewards of the resources with which they are entrusted [20]. They must be able to
21 make treatment recommendations in keeping with their best judgment as medical professionals
22 [21]. And they are expected to uphold the ethical norms of medicine, including fidelity to patients
23 and respect for patients as moral agents and decision makers [22].
24

25 Existing guidance on exercise of conscience by individual physicians suggests essential
26 responsibilities of leadership in health care as well [22]. These include responsibility to engage in
27 thoughtful consideration of the implications of institutional arrangements—whether arrangements
28 sustain or risk undermining the personal and professional integrity of staff, cause moral distress, or
29 compromise the ability to provide care. Leaders in health care institutions must be mindful that
30 arrangements do not discriminate against or unduly burden individual patients or populations of
31 patients, and of the burden arrangements may place on fellow professionals. And they must accept
32 responsibility to take steps to ensure that services will be available to meet the needs of the patients
33 and community the institution serves.
34

35 RECOMMENDATIONS

36
37 In light of this analysis, the Council on Ethical and Judicial Affairs recommends:

- 38
39 1. That Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a
40 Physician's Ability to Provide Patient Centered, Safe Care Services,” be rescinded. (Rescind
41 HOD Policy)
42
43 2. That the following be adopted, and the remainder of this report be filed:
44

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

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

4
5 Physician-leaders within institutions that have or are contemplating a merger should:

- 6
7 (a) Seek input from stakeholders to inform decisions to help ensure that after a
8 consolidation the range of services previously offered will continue to be available to
9 the community.
- 10
11 (b) Be transparent about the values and mission that will guide the consolidated entity and
12 proactively communicate to stakeholders, including prospective patients, physicians,
13 staff, and civic leaders, how this will affect patient care and access to services.
- 14
15 (c) Negotiate contractual issues of governance, management, financing, and personnel that
16 will respect the diversity of values within the community and at minimum that the
17 same range of services remains available in the community.
- 18
19 (d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in
20 consolidated health systems should provide avenues for meaningful appeal and
21 advocacy to enable associated physicians to respond to the unique needs of individual
22 patients.
- 23
24 (e) Establish mechanisms to monitor the effect of new institutional arrangements on
25 patient care and well-being and the opportunity of participating clinicians to uphold
26 professional norms, both to identify and address adverse consequences and to identify
27 and disseminate positive outcomes.

28
29 Individual physicians associated with institutions that have consolidated or propose to
30 consolidate should:

- 31
32 (f) Work to hold leaders accountable to meeting conditions for professionalism within the
33 institution.
- 34
35 (g) Advocate for solutions when there is ongoing disagreement about services or
36 arrangements for care.

(New HOD/CEJA Policy)

Fiscal note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-17)

Introduced by: Medical Student Section

Subject: Disaggregation of Data Concerning the Status of Asian-Americans

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, The pan-ethnic, umbrella term "Asian-American" masks the significant disparities in
2 health outcomes and socioeconomic realities as well as undermines efforts for increased
3 inclusion and representation of students from under-represented Asian countries and cultures,
4 especially in individuals from Laotian, Cambodian, Indonesian, and other backgrounds;^{1,2,3} and
5
6 Whereas, While Chinese American and Asian Indian Americans experience relatively low
7 aggregate poverty rates, at 12.2% and 8.5% respectively, the ethnic groups with the most
8 people in poverty in 2010 were Chinese Americans, with 449,356 people living in poverty, and
9 Asian Indian Americans, with 246,399 people living in poverty, primarily due to the large size of
10 their populations;⁴ and
11
12 Whereas, The 2006 to 2010 aggregate poverty rate by population group was reported as 65%
13 of Bhutanese Americans, 27% for Hmong Americans, and 21% for Bangladeshi Americans;^{4,5,6}
14 and
15
16 Whereas, AB-1726 became law in California, requiring that the Department of Public Health
17 collect disaggregate demographic data to better expose disparities in health care for Pacific
18 Islanders and Southeast Asians, serving as an example for other states to model;^{7,8} and
19
20 Whereas, Pursuant to AMA Policy H-350.966, the AMA urges existing federal agencies,
21 commissions and Asian American and Pacific Islander health organizations to study how to
22 improve the collection, analysis and dissemination of public health data on Asian Americans and
23 Pacific Islanders; therefore be it
24
25 RESOLVED, That our American Medical Association support the disaggregation of data
26 regarding Asian-Americans in order to reveal the within-group disparities that exist in health
27 outcomes and representation in medicine. (New HOD Policy)

¹ Portes A and Rumbaut RG. Children of immigrants longitudinal study (CILS). *Inter-university Consortium for Political and Social Research*. 2012. <http://doi.org/10.3886/ICPSR20520.v2>.

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<http://www.nbcnews.com/news/asian-america/California-governor-signs-bill-disaggregate-asian-american-health-data-n655361>.

⁸ Underrepresented in medicine definition. *Association of American Medical Colleges*. 2017. www.aamc.org/initiatives/urm/.

Fiscal Note: Minimal - less than \$1,000.

Received: 09/20/17

RELEVANT AMA POLICY

Health Initiatives on Asian-Americans and Pacific Islanders H-350.966

Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders.

Res. 404, A-00 Reaffirmed: CSAPH Rep. 1, A-10

See also:

[Medical Education for Members in Underserved Minority Populations H-350.969](#)

[Underrepresented Student Access to US Medical Schools H-350.960](#)

[Reducing Racial and Ethnic Disparities in Health Care D-350.995](#)

[Diversity in Medical Education H-350.970](#)

[Improving the Health of Black and Minority Populations H-350.972](#)

[Racial and Ethnic Disparities in Health Care H-350.974](#)

[Minorities in the Health Professions H-350.978](#)

[Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991](#)

[Addressing Immigrant Health Disparities H-350.957](#)

[Improving the Health of Minority Populations H-350.961](#)

[Cancer and Health Care Disparities Among Minority Women D-55.997](#)

[Strategies for Eliminating Minority Health Care Disparities D-350.996](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-17)

Introduced by: Women Physicians Section

Subject: Intimate Partner Violence Policy and Immigration

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, Most states in the United States have enacted mandatory reporting laws regarding
2 domestic violence, which require the reporting of specified injuries and wounds and suspected
3 abuse or domestic violence for individuals being treated by a health care professional; and
4

5 Whereas, Reports have shown that stated goals of mandated reporting policy of enhancing
6 patient safety, improving health care providers' response to domestic violence, holding
7 perpetrators accountable, and improving domestic violence data collection and documentation
8 mitigate access to and quality of healthcare delivery; and
9

10 Whereas, The laws vary from state-to-state, but generally fall into four categories: states that
11 require reporting of injuries caused by weapons; states that mandate reporting for injuries
12 caused in violation of criminal laws, as a result of violence, or through non-accidental means;
13 and
14

15 Whereas, Three states have exceptions for reporting injuries due to domestic violence (New
16 Hampshire, Oklahoma, and Pennsylvania); and
17

18 Whereas, Our AMA opposes the adoption of mandatory reporting laws for physicians treating
19 competent, non-elderly adult victims of intimate partner violence if the required reports identify
20 victims; and
21

22 Whereas, Current AMA policy states if and where mandatory reporting statutes dealing with
23 competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a)
24 do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of
25 the reporting system if identifiers are required; (c) provide that reports be made to public health
26 agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the
27 efficacy of those laws; and
28

29 Whereas, It has been reported that immigrant women and girls are highly vulnerable to abuse
30 and are statistically twice as likely as non-immigrant females to experience domestic violence;
31 and
32

33 Whereas, There are reports that undocumented domestic violence victims are fearful of seeking
34 healthcare due to concerns of immigration authority involvement; and
35

36 Whereas, Current AMA policy does not specify the use of mandated reporting policies with
37 regard to immigration; and

1 Whereas, The AMA's "Diagnostic and Treatment Guidelines on Domestic Violence", which
2 provided guidance for Interviewing, Diagnosis, Interventions, Documentation, and Risk
3 management regarding domestic violence related care was last updated in 1992 and does not
4 reflect current best practices; therefore be it

5
6 RESOLVED, That our American Medical Association encourage appropriate stakeholders to
7 study the impact of mandated reporting of domestic violence policies on individuals with
8 undocumented immigrant status and identify potential barriers for survivors seeking care
9 (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA work with community based organizations and related stakeholders
12 to clarify circumstances that would trigger mandated reporting of intimate partner violence and
13 provide education on the implications of mandatory reporting on individuals with undocumented
14 immigrant status. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/28/17

RELEVANT AMA POLICY

Gender-Based Violence H-65.974

Our AMA: (1) opposes inhumane treatment of people of both genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof.

Citation: Res. 404, A-06; Modified: CSAPH Rep. 01, A-16

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Citation: Res. 018, A-17

[See also: Family and Intimate Partner Violence H-515.965; Preventing, Identifying and Treating Violence and Abuse E-8.10](#)

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3. Diagnostic and Treatment Guidelines on Domestic Violence. Available at http://www.ncdsv.org/images/AMA_Diag&TreatGuideDV_3-1992.pdf.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-17)

Introduced by: GLMA

Subject: Revision of AMA Policy Regarding Sex Workers

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, The terms “prostitute” and “prostitution” are now considered pejorative labels for
2 individuals who exchange sex for money or goods; and
3

4 Whereas, The medical, public health, and research communities currently utilize the terms “sex
5 work” and “sex workers” to refer to the practice and individuals who exchange sex for money or
6 goods;¹ and
7

8 Whereas, It remains important for our AMA to utilize the most current terminology accepted in
9 the medical and public health communities; and
10

11 Whereas, Our AMA has policy discussing sex workers, but this policy utilizes terminology that is
12 considered outdated and carries a negative connotation towards these individuals; and
13

14 Whereas, Sex work carries a significant stigma that requires continued attention from the
15 medical and public health communities, and which acts as a strong deterrent against sex
16 workers seeking appropriate and compassionate medical care; and
17

18 Whereas, Sex workers face numerous public health detriments, including, but not limited to,
19 violence at the hands of clients and police personnel², psychiatric/mental health issues, sexually
20 transmitted infections, drug abuse and addiction, personal hygiene, and poor access to health
21 care;³ and
22

23 Whereas, Epidemiological and prevalence studies from varied urban and geographical centers
24 report the number of sex workers with concurrent HIV infection to range from 9-33%, depending
25 on the location and population studied;^{4,5,6,7} and
26

27 Whereas, It is predicted that aversion of up to 46% of new HIV infections worldwide could be
28 attained by the decriminalization of sex work and the amelioration of stigma associated with this
29 work;⁸ therefore be it

¹ Dehumanising sex workers: what's 'prostitute' got to do with it? <https://theconversation.com/dehumanising-sex-workers-whats-prostitute-got-to-do-with-it-16444>

² Kerrigan D, Wirtz A, Baral S, N'Jie N, Stanciole A, Butler J, Oelrichs R, Beyer C.

The Global Epidemic Among Sex Workers. Washington DC: World Bank Publications; 201

³ Spice W. Management of sex workers and other high-risk groups. *Occup Med (Lond)* 2007; 57 (5): 322-328.

⁴ Parvez F, Katyal M, Alper H, et al. Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections* 2013;89:280–284.

⁵ Inciardi JA, Surratt HL, Kurtz SP. HIV, HBV, and HCV infections among drug-involved, inner-city, street sex workers in Miami, Florida. *AIDS and Behavior* 2006;10: 139–147.

⁶ Timpson SC, Ross MW, Williams ML, et al. Characteristics, drug use, and sex partners of a sample of male sex workers. *The American Journal of Drug and Alcohol Abuse* 2007;33: 63–69.

⁷ Reisner SL, Mimiaga MJ, Bland S, et al. HIV risk and social networks among male-to-female transgender sex workers in Boston, Massachusetts. *Journal of the Association of Nurses in AIDS Care* 2009;20(5):373–386.

⁸ Shannon K, Strathdee SA, Goldenberg SM, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. *Lancet* 2014;385(9962).

1 RESOLVED, That our American Medical Association amend the text of HOD Policy H-20.898,
2 "Global HIV/AIDS Prevention," by addition and deletion to read as follows:

3
4 H-20.898 Global HIV/AIDS Prevention

5 Our AMA supports continued funding efforts to address the global AIDS epidemic and
6 disease prevention worldwide, without mandates determining what proportion of funding
7 must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or
8 grantee pledges of opposition to ~~prostitution~~ sex work (Modify Current HOD Policy); and be
9 it further

10
11 RESOLVED, That our AMA amend the text of HOD Policy H-20.922, "HIV/AIDS as a Global
12 Public Health Priority," by addition and deletion to read as follows:

13
14 H-20.922 HIV/AIDS as a Global Public Health Priority

15 In view of the urgent need to curtail the transmission of HIV infection in every segment of the
16 population, our AMA:

- 17 (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with
18 medical and public health associations and state governments) develop and implement
19 effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
20 (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic,
21 including research, education, and patient care for the full spectrum of the disease. Public
22 and private sector prevention and care efforts should be proportionate to the best available
23 statistics on HIV incidence and prevalence rates;
24 (3) Will join national and international campaigns for the prevention of HIV disease and care
25 of persons with this disease;
26 (4) Encourages cooperative efforts between state and local health agencies, with
27 involvement of state and local medical societies, in the planning and delivery of state and
28 community efforts directed at HIV testing, counseling, prevention, and care;
29 (5) Encourages community-centered HIV/AIDS prevention planning and programs as
30 essential complements to less targeted media communication efforts;
31 (6) In coordination with appropriate medical specialty societies, supports addressing the
32 special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection
33 in women, and initiatives to prevent the spread of HIV infection through ~~prostitutes~~
34 commercial sex;
35 (7) Supports working with concerned groups to establish appropriate and uniform policies for
36 neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related
37 conditions; and
38 (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active
39 tuberculosis infection to countries where HIV/AIDS is pandemic.
40 (9) Supports programs raising physician awareness of the benefits of early treatment of HIV
41 and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to
42 clinical care and partner services (Modify Current HOD Policy); and be it further

1 RESOLVED, That our AMA amend the title and text of HOD Policy H-515.958, "Promoting Safe
2 Exit from Prostitution," by addition and deletion to read as follows:

3
4 H-515.958 Promoting Safe Exit from ~~Prostitution~~ Sex Work

5 Our American Medical Association supports efforts to offer individuals opportunities to a
6 safe exit from prostitution sex work safely if they choose to do so, as well as access to in
7 pursuit of compassionate care and "best practices"-based services whether or not they
8 choose to continue in sex work. Our American Medical Association also and supports
9 legislation for programs that prevent provide alternative employment to individuals choosing
10 to leave sex work and offer alternatives to individuals arrested on sex work charges divert
11 prostitution rather than penalize them it through criminal conviction and incarceration.

12 (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/29/17

RELEVANT AMA POLICY

Global HIV/AIDS Prevention H-20.898

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution.

Citation: Res. 439; A-08

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11;

Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16

Promoting Safe Exit from Prostitution H-515.958

Our American Medical Association supports efforts to offer individuals a safe exit from prostitution in pursuit of compassionate care and best practices and supports legislation for programs that prevent and divert prostitution rather than penalize it through criminal conviction and incarceration.

Citation: Res. 14, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-17)

Introduced by: Michigan

Subject: Tissue Handling

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, There appears to be a movement to pass laws requiring the handling of tissue
2 obtained from the termination of a pregnancy differently than other tissues obtained during a
3 medical procedure; and
4

5 Whereas, These laws propose to require the interment of fetal tissue obtained from the
6 termination of a pregnancy; and
7

8 Whereas, The implementation of these laws has practical implications for patients, health care
9 facilities, and physicians; and
10

11 Whereas, There appears to be no scientific basis for differing requirements; therefore be it
12

13 RESOLVED, That our American Medical Association adopt policy stating that fetal tissue
14 obtained during the termination of a pregnancy should be handled no differently than other
15 tissues obtained during a medical procedure (New HOD Policy); and be it further
16

17 RESOLVED, That our AMA strongly oppose any proposed laws or regulations that would
18 require the handling of fetal tissue obtained during the termination of a pregnancy differently
19 than other tissues obtained during a medical procedure. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/17

RELEVANT AMA POLICY

Right to Privacy in Termination of Pregnancy H-5.993

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

Citation: (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14)

Pregnancy Termination H-5.983

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

Citation: (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

E-7.3.5 Research Using Human Fetal Tissue

Research with human fetal tissue research has led to the development of a number of important research and medical advances, such as the development of polio vaccine. Fetal tissue has also been used to study the mechanism of viral infections and to diagnose viral infections and inherited diseases, as well as to develop transplant therapies for a variety of conditions, for example, parkinsonism.

However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which a woman's decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues.

To protect the interests of pregnant women as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should:

- (a) Abstain from offering money in exchange for fetal tissue.
- (b) In all instances, obtain the woman's voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the woman of a right to refuse to participate.
- (c) Ensure that when fetal tissue from an induced abortion is used for research purposes:
 - (i) the woman's decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes;
 - (ii) decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant woman.
- (d) Ensure that when fetal tissue is to be used for transplantation in research or clinical care:
 - (i) the donor does not designate the recipient of the tissue;
 - (ii) both the donor and the recipient of the tissue give voluntary, informed consent.
- (e) Ensure that health care personnel involved in the termination of a pregnancy do not benefit from their participation in the termination, or from use of the fetal tissue for transplantation.

[AMA Principles of Medical Ethics: I,III,IV,V](#)

E-7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman.

[AMA Principles of Medical Ethics: I,III,V](#)

Fetal Tissue Transplantation Research H-5.992

Our AMA (1) supports continued research employing fetal tissue obtained from induced abortion, including investigation of therapeutic transplantation; and (2) demands that adequate safeguards be taken to isolate decisions regarding abortion from subsequent use of fetal tissue, including the anonymity of the donor, free and non-coerced donation of tissue, and the absence of financial inducement.

Citation: (Res. 170, I-89; Reaffirmed by Res. 91, A-90; Modified: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Use of Fetal Tissue for Legitimate Scientific Research H-5.994

The AMA supports (1) the concept of the use of fetal tissue for legitimate scientific research, including transplantation; and (2) continued federal funding for such research.

Citation: (Res. 26, I-88; Reaffirmed: Res. 91, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Fetal Tissue Research H-5.985

The AMA supports the use of fetal tissue obtained from induced abortion for scientific research.

Citation: (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-17)

Introduced by: American Academy of Pain Medicine

Subject: Protection of Physician Freedom of Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, Physicians have a First Amendment right to express their good faith views on medical
2 therapies and other medical issues; and
3

4 Whereas, Physicians' rights to express their good faith views on medical issues should not be
5 lost because those views are expressed at seminars or other programs at which the physicians
6 are paid by the sponsor; and
7

8 Whereas, Physicians have been, and increasingly are being, sued for doing nothing more than
9 expressing their views on such topics as use of opioids in treating chronic pain and use of
10 marijuana for medical treatment purposes; and
11

12 Whereas, Lawsuits challenging the expression of a physician's opinion on medical issues are
13 often directed against key opinion leaders in the particular medical specialty; and
14

15 Whereas, The defense of cases in which physicians are sued for expressing their good faith
16 views on medical issues can be very expensive, can cost more than the available insurance
17 coverage, can cause significant anxiety, and can divert the defendant physicians from their
18 practices; and
19

20 Whereas, The mere bringing of these types of suits will exert a chilling effect on the willingness
21 of physicians to speak out in good faith on such controversial issues as a woman's right to
22 choose termination of pregnancy, treatment of Attention Deficit Disorder, the role of marijuana in
23 medical treatment, use of opioids to treat chronic pain, and the efficacy of annual mammograms
24 and PSA screening; therefore be it
25

26 RESOLVED, That our American Medical Association strongly oppose litigation challenging the
27 exercise of a physician's First Amendment right to express good faith opinions regarding
28 medical issues (New HOD Policy); and be it further
29

30 RESOLVED, That our AMA's House of Delegates encourage the AMA Litigation Center to
31 provide such support to a constituent or component medical society whose members have been
32 sued for expressing good faith opinions regarding medical issues as the Litigation Center
33 deems appropriate in any specific case. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/11/17

References:

Luberda v. Purdue Frederick Corp Civil Action No 4:13-cv-00897 S District Court D. So Carolina, Florence Division, filed 4/3/13 (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

County of Suffolk v PurduePharma et al, State of New York Supreme Court Index# 613760/2016; filed 8/31/16 and numerous similar cases brought separately by different counties in New York (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

City of Lorain (Ohio) v. PurduePharma et al, Ohio Northern District Court Case #: 1:17-cv-01639, filed 8/4//17 (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

Conant v. Walters, 309 F.3d 629 (9th Cir. 2002), filed 9/7/00 (advocacy of use of marijuana for medical treatment purposes).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-17)

Introduced by: Minority Affairs Section

Subject: Physicians' Freedom of Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

1 Whereas, The First Amendment of the U.S. Constitution states that “Congress shall make no
2 law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging
3 the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to
4 petition the government for a redress of grievances;” and
5

6 Whereas, There are over 3 billion active social media users around the world; and
7

8 Whereas, Studies indicate that Internet usage by physicians now exceeds 80% for professional
9 communication, research, and networking; and
10

11 Whereas, Physicians have been disciplined or terminated by employers for expressing their -
12 personal viewpoints using their personal social media accounts; and
13

14 Whereas, AMA has existing policy that outlines the right of physicians to advocate for change in
15 law and policy, in the public arena, and within their institutions; therefore be it
16

17 RESOLVED, That our American Medical Association encourage the Council on Ethical and
18 Judicial Affairs to amend Ethical Opinion 1.2.10, “Political Action by Physicians,” by addition to
19 read as follows:
20

21 E-1.2.10 Political Action by Physicians

22 Like all Americans, physicians enjoy the right to advocate for change in law and
23 policy, in the public arena, and within their institutions. Indeed, physicians have an
24 ethical responsibility to seek change when they believe the requirements of law or
25 policy are contrary to the best interests of patients and community health. However,
26 they have a responsibility to do so in ways that are not disruptive to patient care.

27 Physicians who participate in advocacy activities should:

28 (a) Ensure that the health of patients is not jeopardized and that patient care is not
29 compromised.

30 (b) Avoid using disruptive means to press for reform. Strikes and other collection
31 actions may reduce access to care, eliminate or delay needed care, and interfere with
32 continuity of care and should not be used as a bargaining tactic. In rare
33 circumstances, briefly limiting personal availability may be appropriate as a means of
34 calling attention to the need for changes in patient care. Physicians should be aware
35 that some actions may put them or their organizations at risk of violating antitrust laws
36 or laws pertaining to medical licensure or malpractice.

37 (c) Avoid forming workplace alliances, such as unions, with workers who do not share
38 physicians’ primary and overriding commitment to patients.

- 1 (d) Refrain from using undue influence or pressure colleagues to participate in
2 advocacy activities and should not punish colleagues, overtly or covertly, for deciding
3 not to participate.
4 Furthermore, physicians:
5 (e) Should indicate they are expressing their personal opinions, which are guaranteed
6 under the First Amendment of the U.S. Constitution, and should refrain from implying
7 or stating that they are speaking on behalf of their employers;
8 (f) Should be allowed to express their personal opinions publicly without being
9 subjected to disciplinary actions or termination. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 10/12/17

References:

[Physicians and the First Amendment](#)

RELEVANT AMA POLICY

E-1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

E-2.3.4 Political Communications

Physicians enjoy the rights and privileges of free speech shared by all Americans. It is laudable for physicians to run for political office; to lobby for political positions, parties, or candidates; and in every other way to exercise the full scope of their political rights as citizens. Physicians may exercise these rights individually or through involvement with professional societies and political action committees or other organizations.

When physicians wish to express their personal political views to a patient or a patients family, the physician must be sensitive to the imbalance of power in the patient- physician relationship, as well as to the patients vulnerability and desire for privacy. Physicians should refrain from initiating political conversations during the clinical encounter.

Physicians must not allow differences with the patient or family about political matters to interfere with the delivery of professional care.

When expressing political views to a patient or a patients family, physicians should:

- (a) Judge both the intrusiveness of the discussion and the patients level of comfort before initiating such a discussion.
- (b) Discuss political matters only in contexts where conversation with the patient or family about social, civic, or recreational matters is acceptable.
- (c) Refrain from conversation about political matters when the patient or family is emotionally pressured by significant medical circumstances.

(d) Work towards and advocate for the reform and proper administration of laws related to health care. Physicians should stay well informed of current political questions regarding needed and proposed reforms.

(e) Stay well informed about needed or proposed policies concerning health care access and quality, medical research, and promoting public health so as to be able to advocate for patients needs.

Free Speech Applies to Scientific Knowledge H-460.895

Our AMA will advocate that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment.

Citation: Res. 228, A-17

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Citation: Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15