Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

02  New Specialty Organizations Representation in the House of Delegates
15  No Compromise on Anti-Female Genital Mutilation Policy
19  CEJA and House of Delegates Collaboration

CC&B Report(s)

01  Updated Bylaws - Emergency Business
02  Specialty Society Allocation for House of Delegates Representation

CEJA Report(s)

01  Amendment to E-2.3.2, "Professionalism in Social Media"
02  Competence, Self-Assessment and Self-Awareness
03  Ethical Physician Conduct in the Media
04  CEJA's Sunset Review of 2007 House Policies

CLRDPD Report(s)

01  Delegate Allocation for Specialty Societies

Resolution(s)

001  Participation of Physicians on Healthcare Organization Boards
002  Care of Women and Children in Family Immigration Detention
003  Medical Spectrum of Gender
004  Policy on Quarantine
005  Perioperative Do No Resuscitate Orders
006  Increasing Access to Healthcare Insurance for Refugee Populations
007  Healthcare as a Human Right
008  Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation
009  Commercial Exploitation and Human Trafficking of Minors
010  Access to Basic Human Services for Transgender Individuals
011  Revision of Researcher Certification and Institutional Review Board Protocols
012*  Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians
013*  Gender Identity Inclusion and Accountability in REMS
014*  The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying
015*  Appropriate Placement of Transgender Prisoners

* Contained in Handbook Addendum
The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). A summary of each group’s membership data is attached to this report Exhibit A. A summary of the guidelines is attached under Exhibit B.

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit C.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by the organization’s explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. All three organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2016 Interim Meeting indicated that: American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That the American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery be granted representation in the AMA House of Delegates. (Directive to Take Action)

Fiscal Note: Less than 500 to implement.

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APPENDIX

*Exhibit A - Summary Membership Information*

<table>
<thead>
<tr>
<th>Organization</th>
<th>AMA Membership of Organization’s Total Eligible Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Society of Hematology</td>
<td>1,017 of 7,046 (14%)</td>
</tr>
<tr>
<td>American Society of Transplant Surgeons</td>
<td>142 of 659 (22%)</td>
</tr>
<tr>
<td>International Society of Hair Restoration Surgery</td>
<td>106 of 209 (37%)</td>
</tr>
</tbody>
</table>
GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (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:
   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been 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 5 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.
Exhibit C

**RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS**

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting

5. To provide information and data to the AMA when requested.
Resolution 5-I-16, “No Compromise on Anti-Female Genital Mutilation Policy,” sponsored by M. Zuhdi Jasser, MD (Arizona Delegation), was referred to the Board of Trustees. Resolution 5-I-16 asked:

1. That our American Medical Association reaffirm its policy against female genital mutilation (FGM).

2. That, due to the public debate in 2016 over whether the medical community sanctions a proposed “nicking procedure,” our AMA must further clarify its current position on FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not limited to, “nicking” or “genital alteration” procedures done to the genitals of women and girls.

3. That our AMA, on behalf of the medical community, actively advocate against the practice of FGM in all its forms (including the recently proposed “nicking” and “alteration” procedures) and effectively add the voice of America’s physicians to the voices of many anti-FGM human rights activists and their organizations which advocate for the survivors and victims of FGM.

4. That our AMA partner in this public advocacy with reputable anti-FGM activists and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project, and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few.

5. That our AMA educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm of any and all forms of FGM.

Testimony heard during the reference committee hearing strongly favored the spirit of this resolution. Concerns were stated over the fourth resolve (asking the AMA to partner with specific advocacy groups and survivors of FGM); the author of the resolution agreed that it was not appropriate to state specific groups or people without proper vetting and thus agreed that the fourth resolve should be removed. The reference committee recommended that the remainder of the resolution be worded more strongly, adding specifically that additional policy be created to state that any physician who participates in FGM should be considered unethical. This change was debated on the floor of the House. In addition, questions were raised about what should be considered “mutilation” (cosmetic labial reconstruction and gender reassignment surgery were
cited), and concerns were raised regarding the freedom to practice strongly held cultural traditions. Thus, this resolution was referred to the Board of Trustees. This report summarizes the AMA’s position on female genital mutilation (FGM) and compromise procedures, and provides recommendations in response to the resolution.

BACKGROUND

According to the World Health Organization, female genital mutilation (FGM) comprises “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons [1].” The WHO delineates the different methods of FGM into four distinct categories, which are widely accepted and cited:

Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris, and in very rare cases, only the prepuce.

Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

These procedures can cause early and late complications. Early complications include bleeding, infection and urinary retention [2,4], though it should be noted that bleeding and infection are risks associated with virtually any procedure. Late and severe complications include urinary complications, scarring, pain, infection, pelvic inflammatory disease, infertility, stillbirth stemming from obstructed labor, postpartum hemorrhage, sexual dysfunction, and death [2-4]. Emerging evidence also suggests that FGM can cause long-term harms to mental health and post-traumatic stress disorder [2,3,10].

Each year, approximately 3.3 million girls worldwide, including 513,000 U.S. women and girls, are at risk of undergoing the procedure [1]. Female genital mutilation is most commonly practiced in Africa, the Middle East, Asia, and among immigrant communities in the US [1]. The procedure is variously seen as a rite of passage, a necessary precursor to marriage, and a way to preserve virginity, femininity and hygiene. Women and girls undergo FGM in response to societal pressure to conform with peers and on the assumption that FGM prevents promiscuity [1,2]. No matter the origin, the practice is widely held to reflect deep-rooted inequality between the sexes and is recognized internationally as a gender-specific violation of human rights [11]. The U.S. government opposes FGM of any type, degree, severity, or motivation for performing it, and it is against the law to practice FGM in the United States [5].

“Nicking”

In 2016, the Journal of Medical Ethics published an article that proposed “nicking” as an alternative to FGM that can balance respect for cultural values and traditions with preventing harm. The authors argue that a “nick” on the external female genitalia causes little or no functional harm and should be permitted to avoid more extreme procedures. They state that any society that tolerates male circumcision ought to permit female procedures of comparable harm and policies or
campaigns opposing all types of female genital alteration are culturally insensitive. Accordingly, the authors hold that “nicking” is neither gender discrimination (since male circumcision is widely performed) nor a human rights violation [4].

It should be noted that the World Health Organization, UNICEF and the United Nations Population Fund jointly adopted the categorization above, where “nicking” would be considered a Type 4 form of FGM [6,8].

Nicking versus Medical Male Circumcision

Arguments for nicking compare male circumcision as a culturally respectful alternative to FGM [4]. However, this is a false comparison. Male circumcision, of infants, adolescents or adults, may similarly reflect deeply rooted tradition. Unlike FGM or nicking, medical male circumcision is not rooted in discriminatory ideologies and has health benefits. Since 2007, the World Health Organization and Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended male circumcision for protection against sexually transmitted infections. For instance, the inner foreskin is highly susceptible to HIV infection, and circumcision can reduce the risk of female-to-male sexual transmission of HIV by approximately 60 percent. The procedure does not affect the sex organ or deny a normal sexual life [1].

Despite evidence showing the health benefits of male circumcision, the practice is nonetheless becoming less common in the United States [7], for reasons that are not entirely clear.

CURRENT AMA POLICY

AMA first adopted policy strongly opposing FGM in 1994. In 2012, the House of Delegates amended that policy to address the responsibilities of physicians practicing in the US. In its present form, H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,”

(1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States [12].

NICKING AND COMPROMISE SOLUTIONS

According to the most recent UNICEF data [8], the method of FGM where the female genitals were “cut with flesh removed” (as opposed to cut with no flesh removed or genitals sewn closed) was by far the most common practice among the 25 countries for which data are available. In no country except Eritrea was nicking the most prevalent form of FGM. It should be noted however, that ethnicity within a country also plays a role; in Eritrea, the vaginal openings of 100% and 96% of girls of Hedarib and Afar ethnicities, respectively, were sewn completely shut. Of the six
remaining ethnicities identified in this survey for Eritrea, two predominantly practiced nicking and four predominantly practice cutting with flesh removed [8].

There are no readily available data to suggest that permitting nicking would dissuade individuals or families from seeking other, more harmful forms of FGM, even if other forms are legally prohibited. Studying the prevalence of illegal procedures has its own challenges, but to endorse an ethically problematic practice without strong evidence of efficacy is not appropriate. Further, there is little evidence that a nick would satisfy the ritual purpose or physical alterations for which FGM is carried out in the first place. Bodily change is, in many cases, the purpose of the ritual [9]. Verification that the procedure has in fact been performed is expected, whether through functional change (time it takes to urinate), body aesthetics (genitals that are smooth and minimal are seen as more hygienic), or change in sexual satisfaction and drive (in the case of clitoridectomy) [9].

EFFORTS TO ADDRESS FGM

Many organizations worldwide are addressing the issues of FGM. Organizations such as Equality Now and No Peace without Justice promote physician knowledge about FGM worldwide, while others such as The Olmalaika Home create safe houses for girls at risk for FGM in affected countries [13-15].

In the US, it is a felony to perform ritual cutting of any kind on a girl younger than eighteen years of age [2]. In at least one state (Nevada), a person may be prosecuted for the removal of a child from that state for the purpose of having FGM performed on the child [2]. It should also be noted that FGM can be the basis for claiming asylum in the United States [2].

Physicians practicing in the US may encounter patients who have undergone FGM or who request FGM for themselves or a family member. To fulfill their responsibility to provide respectful, culturally sensitive care, as AMA policy provides, physicians must have appropriate medical knowledge and skills and further, must have appropriate language to discuss medical issues with such patients. If asked to perform a type of ritual cut, it is important for the physician, while refusing to do so, to understand that many family members who continue this practice believe that they are doing what is best for their daughters [2].

RECOMMENDATION

In light of the foregoing analysis, which leads to the conclusion that AMA policy in its present form prohibits the practice of “nicking,” the Board of Trustees recommends that Policy H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,” be reaffirmed in lieu of Resolution 5-I-16 and the remainder of this report be filed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

Policy D-600.957, “CEJA and House of Delegates Deliberation,” adopted in June 2016, asks the American Medical Association (AMA) to evaluate:

1. how the collaborative process between the House of Delegates (HOD) and the Council on Ethical and Judicial Affairs (CEJA) can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy; and

2. how a periodic review of Code of Medical Ethics guidelines and reports can best be implemented.

Report 3-I-16, “CEJA and House of Delegates Collaboration,” by the Council on Ethical and Judicial Affairs (CEJA) reviewed Bylaws that set out CEJA’s responsibilities, presentation of its reports and recommendations to the HOD, and actions available to the HOD with respect to CEJA reports and recommendations [1]. Report 3 also described CEJA’s historical practice with respect to soliciting input on matters it was considering and proposed an additional mechanism by which to receive comment on work in progress. However, testimony was offered to the effect that Report 3 did not adequately address important underlying issues of the relationship between the Council and the HOD.

In light of the importance of the Code of Medical Ethics and the potential implications of the concerns expressed in testimony for Bylaws relating to the Council on Ethical and Judicial Affairs, the matter was referred to the Board of Trustees (BOT) for further consideration. Your Board of Trustees believes that the question of review of the Code (D-600.957(2)) is adequately addressed in current AMA policy for the reasons noted below. This report therefore focuses on the issue of collaboration between the Council and the House (D-600.957(1)).

THE CODE OF MEDICAL ETHICS

The Code of Medical Ethics is one of the founding pillars of our American Medical Association and the pre-eminent contemporary statement of the values and commitments of the medical profession overall. In an article celebrating the 150th anniversary of the AMA Code the late physician-philosopher Edmund Pellegrino noted that a code of ethics is “in effect, a collective promise of fidelity”[2]. It is a vehicle that transmits the profession’s “tradition of dedicated service” and translates ethical knowledge and commitment into practice. A code of ethics embodies the “moral truth” of medicine as a special kind of human activity and “defines the integrity of medicine as a moral entity with its foundations in something more than mere social convention.”
A code of ethics thus is the foundation for patient and public trust in medicine as a profession and
undergirds the social contract on which the profession’s freedom to regulate itself depends.
Moreover, by clearly articulating physicians’ primary ethical and professional commitment to
patients, a code of ethics sustains physicians’ role as advocates for patients in the face of ongoing
change in health care.

PERIODIC REVIEW OF THE CODE

The ethics guidance set out in the Principles of Medical Ethics and the Opinions of the Council on
Ethical and Judicial Affairs that make up our AMA Code of Medical Ethics reflect enduring
principles of professional ethics. Thus a thorough review of the Code, such as that just completed
through an eight-year process, should necessarily be rare. The House of Delegates already has
available to it a mechanism by which it can request that a specific Opinion be reconsidered, i.e., by
adopting a resolution so requesting. The Board believes this mechanism could equally be employed
to request review of a broad topic area, e.g., genetic medicine, when advances in medical science,
technology, or practice or evolution of public policy give rise to new ethical challenges or require
clarification of how existing ethics guidance should be interpreted and applied. For these reasons,
your Board of Trustees concludes that D-600.957(2) is adequately addressed in existing AMA
policy and practice.

CEJA-HOD COLLABORATION

Questions about the relationship between the House of Delegates and the Council on Ethical and
Judicial Affairs have arisen from time to time over the years. Such questions were addressed at
length in a joint report by CEJA and the Council on Constitution and Bylaws presented to the HOD
in December 1991 [3]. As that report observed:

Any proposals to clarify the procedures for Council opinions and reports must reflect two
fundamental principles of the Constitution and Bylaws. First, the Council should be given a
substantial degree of independence from the political process of the House as long as it is
genuinely interpreting the Principles of Medical Ethics. Second, the House should be given
mechanisms with which to check and balance the independence of the Council.

The report argued that the independence of the Council on Ethical and Judicial Affairs helps ensure
that stakeholders view the AMA’s ethics guidance as grounded in enduring principles “rather than
the political temperament of the times,” and expressed concern that perception otherwise would
“undermine the legitimacy of the Council” and the stature of the Code as an “authoritative code for
the entire profession.”

The report further noted that the House has several mechanisms for oversight of CEJA activities.
The House can influence the Council’s deliberations through its authority to confirm appointment
of members. Historically, the process of confirming appointment of a new CEJA member has
occurred immediately following announcement of the candidate by the AMA President Elect
during the opening session of each Annual Meeting of the House. In 2016, the nominee’s conflict
of interest disclosure was posted on the Annual Meeting website before the House opened. The
posting was announced in the Speakers’ Letter and by email to the House.

The House can also amend the Principles of Medical Ethics if it finds the Council’s interpretations
problematic. Finally, the House can pass a resolution requesting that the Council reconsider an
opinion with which it disagrees.
The recommendations of this report were adopted as presented and are reflected in current Bylaws relating to the Council on Ethical and Judicial Affairs discussed below.

Current CEJA Practice

CEJA Report 3-I-16 identified several channels through which the Council currently receives input at Annual and Interim meetings about reports in development: Open Forum sessions, testimony in the Reference Committee on Amendments to Constitution and Bylaws, and in response to stakeholder concerns about opportunity to comment on the draft modernized *Code of Medical Ethics*, and special “open house” conversations. The Council proposed to hold open house sessions again at the 2017 Annual and Interim meetings and to collect attendees’ feedback on the value of such sessions.

CEJA also invites written review or presents work in progress in small face-to-face meetings with key stakeholders on a report-by-report basis and posts work in progress to its online forum (www.ama-assn.org/go/cejaforum) for comment by all AMA members and other individuals who have created an AMA account. In addition, the Council receives input between meetings of the House from individuals and delegations who communicate with staff directly.

Having time during Annual and Interim meetings dedicated to giving feedback on CEJA reports and recommendations through the reference committee process offers an efficient way for delegations and individuals to provide input, and CEJA reports benefit significantly from the focused collective attention that reference committee promotes. CEJA reports are only rarely adopted on first presentation to the House and the usually iterative process helps ensure that multiple values are heard and balanced as compellingly as possible in keeping with the Council’s mandate.

RELEVANT AMA POLICY

As CEJA 3-I-16 observed, AMA policy is largely silent with respect to the means by which CEJA should collaborate with the House of Delegates. The Bylaws grant CEJA authority to interpret the Principles of Medical Ethics (6.5.2.1) and to investigate and make recommendations to the House regarding “general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public” (6.5.2.3). Bylaw 2.13.1.1 provides that all matters pertaining to the Principles of Medical Ethics, including CEJA reports, be referred to the Reference Committee on Amendments to Constitution and Bylaws. Bylaw 2.13.1.7.2 provides that CEJA Opinions be treated as informational and filed and that motions may be made to extract an opinion and a request made to CEJA to withdraw or reconsider it. Bylaw 2.13.1.7.2 also provides that the House may adopt, refer, or not adopt CEJA reports, but that they may be amended only with the concurrence of the Council.

Policy G-615.040, “Opinions and Reports of CEJA,” provides that CEJA will present its opinions as informational and may provide to the House an analysis of issues and explanation for its opinion at the Council’s discretion. G-615.040 also replicates provisions of Bylaw 2.13.1.7.2 regarding treatment of CEJA opinions, as well as provisions regarding the treatment of CEJA reports.

OPPORTUNITIES TO ENHANCE COLLABORATION

The Board of Trustees concurs that, as the 1991 CEJA-CCB joint report argued, balancing independence and oversight are key for productive, collegial collaboration between the Council on Ethical and Judicial Affairs and the House of Delegates. The integrity and stature of the *Code of*
Medical Ethics as guidance for all physicians require that CEJA be able to carry out its
deliberations independent of the political process of the House of Delegates. That includes not only
identifying areas in which ethics guidance is called for, but also being able to define the scope of
ethics guidance so as to address key underlying ethical issues rather than direct its reports and
recommendations to specific incidents or “trouble cases” even when a resolution may expressly
seek clarification about ethically appropriate conduct only in very particular circumstances.

At the same time, it is essential that the Council conduct its work as transparently as possible,
identifying appropriate opportunities for input, discussion, and debate as it develops ethics
guidance for the AMA. CEJA has proposed to schedule regular “open house” conversations at
Annual and Interim meetings going forward and to solicit feedback on the utility of such sessions.
The Board believes this proposal has potential to improve collaboration between the HOD and the
Council.

CEJA’s internal work process may also lend itself to creating additional opportunities for the
Council to receive feedback. CEJA reports are developed through an iterative, multi-stage process
that begins with a review of key literature to identify salient issues and continues through
development of the Council’s foundational ethics analysis in discussion over multiple meetings,
and finally drafting of recommendations based on the ethics analysis. CEJA could post work
product at one or more of these various stages to offer AMA members and other AMA account
holders additional opportunity to share feedback with the Council.

The Board recognizes, however, that the greatest opportunity for significant collaboration between
CEJA and the House takes place at the Annual and Interim meetings. CEJA’s project to modernize
the Code of Medical Ethics may be instructive in addressing this issue. In response to concerns that
the draft Code was too complex to be included as one item of business among many others on the
docket of the Reference Committee on Amendments to Constitution and Bylaws, at the 2015
Interim and 2016 Annual meetings the Speakers convened a special reference committee dedicated
solely to hearing testimony on the draft modernized Code. While the Board appreciates that
dedicating a reference committee to CEJA business poses considerable logistic challenge; it is
conceivable that the volume, complexity or nature of CEJA reports and opinions may again rise to
the level to justify a separate reference committee.

CONCLUSION

The AMA Code of Medical Ethics was the first national professional code of ethics in the world
and remains the authoritative statement of medicine’s ethical commitments. Ensuring that the Code
continues to provide timely guidance is one of the core responsibilities of our AMA.

The AMA House of Delegates brings a wide range of professional expertise and experience as well
as diverse personal and professional views to matters of ethics in the practice of medicine. The
House thus offers an invaluable proving ground for ethics guidance that transcends specialties and
practice settings to speak to the profession as a whole.

At the same time, the House offers a unique opportunity and a distinctive challenge for the Council
on Ethical and Judicial Affairs tasked to create that policy: to respect this diversity while ensuring
that guidance remains strongly grounded in the “moral truth” of medicine tempered by the insights
from contemporary bioethics, independent of political processes.
RECOMMENDATION

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the Council on Ethical and Judicial Affairs be encouraged to carry forward its proposals for enhancing transparency and opportunity for input. (New HOD Policy)

2. That the Speakers are encouraged to consider convening a separate reference committee at Annual or Interim meetings of the House of Delegates dedicated to reports and recommendations of the Council on Ethical and Judicial Affairs when appropriate and feasible. (New HOD Policy)

3. That the President-Elect and the Speakers are encouraged to consider formalizing a process of announcing a candidate for CEJA membership before the House is asked to confirm the candidate. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000.
REFERENCES


REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-17

Subject: Updated Bylaws – Emergency Business

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

At the 2016 Interim Meeting of the AMA House of Delegates, the Council on Constitution and Bylaws presented CCB Report 2-I-16, “Bylaw Amendments pertaining to Late Resolutions and Emergency Business.” CCB Report 2-I-16 was prepared to implement Policy G-600.054, “Procedures of the House of Delegates,” which changed how the House of Delegates handled late and emergency resolutions. Policy G-600.054 had its origins in Speakers Report 1-A-16, which, among other things, articulated why references to the “final day” of a House of Delegates meeting in our AMA Bylaws were inadvisable. The House adopted CCB Report 2-I-16 Recommendation 1 in regard to late resolutions introduced by delegates and referred Recommendation 2 regarding the handling of reports back to the Council. As the Council noted in its report and subsequent reference committee testimony, eliminating all bylaw references to the “final day” of the meeting was problematic for a number of reasons, not the least of which were that it had no House input on section resolutions and Board and council reports submitted after the opening session of the House of Delegates recessed.

This report presents amended bylaw language for consideration of the House of Delegates (HOD). In formulating its recommendations, the Council took into consideration the testimony during reference committee on its original recommendations.

BACKGROUND

The following bylaws contain reference to the final day of the House of Delegates meeting:

- 2.11.3.1.2, AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates at any time before the close of business on the day preceding the final day of the meeting.

- 2.11.3.3, Reports of Councils. Reports, opinions, or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time before the close of business on the day preceding the final day of a meeting.

- 2.11.5, New Business on Final Day of House of Delegates Meeting.

- 2.11.5.1, Requirements. Reports, recommendations, resolutions or other new business presented by the Board of Trustees on the final day of a meeting shall be accepted as business before the House and shall not be referred to a reference committee, but adoption of the recommendation(s) in the report or other item(s) of business shall require a three-fourths vote of delegates present and voting.

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AMA Section Resolutions

As recommended by Speakers Report 2-A-16, adopted by our AMA House of Delegates and codified in Bylaw 2.11.3.1.4, resolutions submitted by delegates after the HOD opening session is recessed are deemed emergency resolutions and are accepted as business only upon a three-fourths vote of delegates present and voting. These emergency resolutions are then presented to the House as a whole and do not receive consideration by a reference committee.

The Council has confirmed with the Office of House of Delegates Affairs that section resolutions typically are submitted early enough for the advance Handbook or for inclusion in the Sunday tote, and thus are referred to a reference committee for deliberation and recommended disposition. Under our current Bylaws, these resolutions are not considered “late” or “emergency.”

Reports of the Councils and the Board of Trustees

Current AMA Bylaws allow the Board to submit a report any time during a meeting but a Board report submitted on the final day, while automatically accepted, requires a three-fourths vote for adoption of its recommendations.

With the exception of the Council on Constitution and Bylaws, it is rare for a council or the Board to submit an onsite report. The Council on Constitution and Bylaws is generally the only council that regularly submits onsite reports and those respond to adopted resolutions or reports that call for amendments to the AMA Bylaws, have some immediacy, and are simple and/or straightforward.

The majority of council reports require only a majority vote to adopt, although there are exceptions when it comes to changes to the AMA Constitution, Bylaws and Principles of Medical Ethics. Reports that recommend changes to our AMA Bylaws require a two-thirds vote for adoption rather than a majority.

DISCUSSION

Much of the testimony heard during reference committee focused on one or more of the following categories: consistency between Board and council reports; voting parameters for consideration and/or adoption; and the timing of a report’s submission. There seemed to be general agreement on several points:

1) The requirements for Board and council reports should be consistent as these reports are written by physicians elected by the House or appointed by the Board;

2) The threshold for accepting a Board report for HOD consideration should not be higher than that for council reports; and

3) Items of business that bypass the normal reference committee deliberative process should have some type of hurdle but one that is not insurmountable.

AMA Sections

The Council noted that there was no testimony opposing its language regarding section resolutions. Thus, the Council again is proposing that resolutions from the business meetings of the AMA sections be presented no later than the recess of the House of Delegates opening session so that they can be referred to a reference committee for consideration.
Also, the Council added a provision to specify that section resolutions received after the recess of the HOD opening session and thus received too late to be referred to reference committee are handled consistently with how emergency resolutions from the constituent associations and national medical specialty societies are managed. While the Council knows that a section resolution rarely would be submitted after the recess of the Opening Session, it supports consistency and equity among all resolutions. It thus recommends that a section resolution submitted after the recess of the HOD opening session should be treated similarly to emergency resolutions submitted by other entities and require the same three-fourths vote for acceptance.

**Board and Council Reports submitted after recess of the Opening Session**

The Council considered putting all Board reports and council reports on a footing equal to that of emergency resolutions (a three-fourths vote for consideration), but agreed with reference committee testimony that such a vote to consider a Board or council report was not needed since the subject of such a report has already been vetted by AMA leadership. Most reference committee testimony indicated that Board reports, regardless of when submitted, should not be subject to any type of hurdle to be considered. The Council agrees that items of business presented by the Board or a council should always be considered.

The Council proposes elimination of Bylaw 2.11.5 as this provision focuses on new Board business on the final day of an HOD meeting. This provision also stipulates that Board items submitted on a final day are automatically accepted but require a three-fourths vote to adopt.

**Adoption of Emergency Items of Business**

The Council noted that prior to adoption of Speakers Report 2-A-16, emergency resolutions required a three-fourths vote to adopt but that Speakers Report 2-A-16 redefined an emergency resolution from one submitted on the final day to one submitted after the recess of the opening session. It also modified the three-fourths vote to adopt to a three-fourths vote to accept and a majority to adopt. The Council agrees with requiring a three-fourths vote to accept emergency resolutions. However, the Council feels the all emergency items of business should have to meet the same bar—a two-thirds vote—for adoption.

The Council believes that all items of business (resolutions, business from the Board and business from a Council) submitted after the opening session of the HOD should be defined as emergency business. The Council further proposes a two-thirds vote for adoption of all emergency business to compensate for the fact that they bypass the normal reference committee process. Reference committee testimony is integral to our AMA’s democratic process as delegates have a responsibility to make an educated decision when voting for or against an item of business no matter who presents it. If an item of business is urgent enough to be considered without deliberation by the normal reference committee process, it should be able to meet the reasonable higher bar of a two-thirds vote for adoption. Among other options, the House may refer an item to the council or Board by simple majority vote if it believes further information or analysis is needed.

**RECOMMENDATIONS**

The Council on Constitution and Bylaws recommends the following and that the remainder of this report be filed:

1. That the following amendments to the AMA Bylaws be adopted:
2.11 Procedure.

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2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization’s house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates at any time before the close of business on the day preceding the final day of the meeting no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds
vote of the delegates present and voting shall be required for adoption.

2.11.3.1.6 **Resolutions not Accepted.** Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 **Business of from the Board of Trustees.** Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 **Reports of Business from the Councils.** Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time before the close of business on the day preceding the final day of a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

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2.11.5—New Business on Final Day of House of Delegates Meeting.

2.11.5.1 **Requirements.** Reports, recommendations, resolutions or other new business presented by the Board of Trustees on the final day of a meeting shall be accepted as business before the House and shall not be referred to a reference committee, but adoption of the recommendation(s) in the report or other item(s) of business shall require a three-fourths vote of delegates present and voting.

(Modify AMA Bylaws)

2. That Policy G-600.054(6) and (7) be rescinded. (Modify Current HOD Policy)

Fiscal Note: Less than $500
RELEVANT AMA POLICY

G-600.054 - Procedures of the House of Delegates
1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
   A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
   B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. Late resolutions are defined as those submitted less than 30 days before the opening day of a House of Delegates meeting but before the opening session recesses and not meeting the definition of regular business, and that business submitted after the recess of the opening session be regarded as emergency business, subject to a three-fourths vote for acceptance as business.
7. The Council on Constitution and Bylaws will prepare bylaws amendments to effect the changes in definitions as well as handling of late resolutions and emergency business and as part of that effort consider whether some related elements currently in the bylaws would better exist in policy.
8. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.
Subject: Specialty Society Allocation for House of Delegates Representation

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

At the 2016 Interim Meeting of the AMA House of Delegates, the House adopted Policy G-600.027, “Designation of Specialty Societies for Representation in the AMA House of Delegates,” which established a new specialty society allocation method that eliminated the need for a ballot and which assured parity between the AMA delegates apportioned to national specialty society delegates and those apportioned to constituent societies. The policy also called for the Council on Constitution and Bylaws to investigate the need to change any policy or bylaws needed to implement the revised specialty society allocation process and specified a two-step process to annually determine the allocation based on the latest membership data.

This report presents the necessary bylaw amendments for the House’s consideration. Each specialty society’s delegate allocation will be determined annually. Those physicians or other professionals who are AMA affiliate members, honorary members and international members are excluded so that constituent association apportionment and national medical specialty society apportionment are both based on active members of the AMA. The total number of delegates apportioned to national medical specialty societies is then adjusted to be equal to the total number of delegates apportioned to constituent societies using methods specified in AMA Policy G.600.027.

The Council also draws the House’s attention to a companion report from the Council on Long Range Planning and Development (CLRPD Report 1-A-17) which recommends additions to AMA policy to address how delegates will be allocated for societies newly represented in the AMA House of Delegates and how to handle delegates from national specialty societies that lose the privilege of representation by a delegate in the House. The new apportionment formula will not take effect until 2018.

RECOMMENDATIONS

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

The Council emphasizes that while our AMA Bylaws will change as soon as the House adopts the amended language, the new apportionment formula will not take effect until 2018, with the new allocation process first implemented at the 2018 Annual Meeting. As allocations are done annually on a calendar basis, the apportionment figures released in January 2017 apply for the full year.
2.1 Constituent Associations. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

2.1.1.2 Unified Membership. A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment during the first 2 years in which the unified membership bylaw provisions are implemented.

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1.1 using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate for each 1,000, or fraction thereof, physician members or fourth year medical student specialty society members as of December 31 of each year who have full voting privileges, are eligible to hold office in that society, are active members of the AMA or who select that specialty society to represent the member or who are allocated to that specialty society by extrapolation methods specified in AMA policy and are members in good standing of both the specialty society and the AMA. The
delegates eligible for seating in the House of Delegates by apportionment are in addition to the additional delegate and alternate delegate authorized for unified specialty societies meeting the requirements of Bylaw 2.2.2.

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.2.2 Additional Delegate. A specialty society that has adopted and implemented bylaw provisions requiring unified membership is entitled to one additional delegate. If during any calendar year the specialty society adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the specialty society shall be entitled to the additional delegate. The specialty society shall retain the additional delegate only if the membership information recorded by the AMA as of each subsequent December 31 confirms that all of the specialty society’s members are members of the AMA.

(Modify AMA Bylaws)

EXISTING POLICY

G-600.027, Designation of Specialty Societies for Representation in the House of Delegates
1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society’s most recent five year review, but may be determined annually at the society’s request.
2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process: (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof. (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies. (i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates. (ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates. (iii) In the case of a tie, the previous year’s data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.
3. The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.
4. This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.
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.


Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates….
Subject: Amendment to E-2.3.2, “Professionalism in Social Media”

Presented by: Ronald J. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

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

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

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

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

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

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

USES OF SOCIAL MEDIA FOR EDUCATION OR ADVOCACY

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

Some applications, such as Figure 1™, only allow deidentified photos to be posted. Users must remove identifying information before posting (faces, tattoos, etc.) and all photos undergo additional verification before being posted. Patients must also consent to their photo being shared. Additionally, users of the application are asked for their occupational information and only healthcare professionals can comment or upload photos. Forums like Reddit or Twitter have no such safeguards. It is solely up to the physician to comply with ethical guidelines and not post identifying information or other inappropriate information online.

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

RECOMMENDATION

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

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

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
(b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.

(c) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

(d) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.

(e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500
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.
The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

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

**DEFINING COMPETENCE**

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

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

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

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

SELF-ASSESSMENT & ITS LIMITATIONS

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

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

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

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

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

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

EXPERTISE & EXPERT JUDGMENT

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

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

INFLUENCES ON CLINICAL REASONING

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

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

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

Habits of Perception

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

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

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [29]. Overconfidence in one’s abilities can
lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the
time of others, or not acknowledging one’s limits [27, 29].

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

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

FROM SELF-ASSESSMENT TO SELF-AWARENESS

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

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

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

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

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

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

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

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

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

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

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

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

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

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

RECOMMENDATION

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

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

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

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

(a) Exercise continuous self-awareness and self-observation;
(b) Recognize that different points of transition in professional life can make different
demands on competence;

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice
settings and patient populations;

(d) Seek feedback from peers and others;

(e) Be attentive to environmental and other factors that may compromise their ability to bring
appropriate skills to the care of individual patients and act in the patient’s best interest.

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

(f) Developing appropriate ways to assess knowledge and skills across the professional
lifecycle;

(g) Providing meaningful opportunity for physicians and physicians in training to hone their
ability to be self-reflective and attentive in the moment;

(h) Supporting efforts to develop more and better techniques to address gaps in knowledge,
skills, and self-awareness.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-17

Subject: Ethical Physician Conduct in the Media

Presented by: Ronald J. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

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

PHYSICIANS IN THE PUBLIC SPHERE

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

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

A CONTINUUM OF ROLES

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

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

* 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.

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

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

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

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

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

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

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

FIDELITY, TRUST, AND DIVIDED LOYALTIES

For physicians in the media, then, navigating successfully among the potentially overlapping roles
of clinician, expert consultant, journalist, or (for some) media personality poses challenges. Being
clear about what role(s) they are playing at any given time is crucial [3]. So is being aware of how
media content they create or the media presence they have blurs the lines of medicine, journalism,
and entertainment [3, 5].
For a physician who pursues a distinct career as a singer, a dancer, or a cook on the line in a restaurant kitchen, the new role is entirely different than that of a physician [6]. But when a media career involves depending on the inherent authority of their MD or DO degree rather than their training and skills, physicians in the media are taking advantage of the credibility and prestige bestowed by the public and the media on members of the medical profession [6, 7]. It may never occur to a cancer patient watching a physician on television that “someone highly credentialed might mix critical medical advice with a touch of ‘shock and awe’” even when such behavior might be condemned by other physicians and the medical profession as a whole [7].

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

Trustworthiness and Authoritativeness

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

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

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

Maintaining Privacy in the Public Eye

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

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

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

CONFLICTS AND DISCLOSURES

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

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

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

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

Instituting measures to promote independent content is a further important step. For example, 
editorial review of proposed content and presentation can help identify possible bias or the 
appearance of bias or catch elements that media consumers might be expected to misinterpret. 
Prohibiting physicians who have clear, unresolved competing interests from being media
spokespersons on issues that involve those interests can likewise help ensure independence [24].
Making explicit to viewers the measures taken to address and mitigate the influence of conflicts of interest will hold media physicians accountable to their peers and the public for exercising sound professional judgment.

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

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

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

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

(a) Always remember that they are physicians first and foremost, and must uphold the values and norms of the medical profession.

(b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.

(c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.

(d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:

   (i) accurate

   (ii) inclusive of known risks and benefits
(iii) based on valid scientific evidence and insight gained from professional experience

(e) Confine their medical advice to their primary area(s) of expertise, and clearly distinguish the limits of their medical knowledge where appropriate.

(f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.

(g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.

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

(New HOD/CEJA Policy)

Fiscal Note: Less than $500
REFERENCES


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

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

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

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

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

2007 POLICIES

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

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

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

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

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, “Pediatric Decision-Making.” It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council’s 2009 sunset report.

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

RECOMMENDATION

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

Fiscal Note: Less than $500.
## APPENDIX - RECOMMENDED ACTIONS

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Title</th>
<th>Recommended Action &amp; Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-20.915</td>
<td>HIV/AIDS Reporting, Confidentiality, and Notification</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-65.979</td>
<td>Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth Organization</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-65.983</td>
<td>Nondiscrimination Policy</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-65.988</td>
<td>Organizations Which Discriminate</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-140.896</td>
<td>Moratorium on Capital Punishment</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-140.900</td>
<td>A Declaration of Professional Responsibility</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-140.978</td>
<td>Financial Incentives to Limit Care – Ethical Implications for HMOs and IPAs</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-445.996</td>
<td>Public Awareness and Education</td>
<td>Rescind: Policy is outdated and no longer remains relevant.</td>
</tr>
<tr>
<td>H-445.998</td>
<td>Proprietary of Professional Public Communications</td>
<td>Retain: Policy remains relevant</td>
</tr>
<tr>
<td>H-460.919</td>
<td>Privacy and Confidentiality</td>
<td>Rescind: Policy is outdated and no longer remains relevant.</td>
</tr>
<tr>
<td>D-20.991</td>
<td>Ethical and Legal Issues in Responding to Occupational HIV Exposure</td>
<td>Rescind: Recommendation of CEJA Report 4 were adopted following the adoption of this resolution.</td>
</tr>
<tr>
<td>D-250.990</td>
<td>Israeli Medical Association</td>
<td>Rescind: No change in the status of the Israeli Medical Association’s membership with the World Medical Association took place.</td>
</tr>
</tbody>
</table>
At the American Medical Association’s (AMA) 2016 Interim Meeting the House of Delegates (HOD) adopted Policy G-600.027, “Designation of Specialty Societies for Representation in the House of Delegates,” which created a new specialty society delegation allocation system. Under this new system, the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent (i.e., geographic) societies under section 2.1.1 (and subsections thereof) of the AMA bylaws. A companion report by the Council on Constitution and Bylaws (CCB Report 2-A-17) proposes bylaws changes related to this policy.

This report by the Council on Long Range Planning and Development (CLRPD) proposes two additions to Policy G-600.027 for the consideration of the HOD. These additions relate to two situations not explicitly addressed by the policy as written but raised during debate in the HOD. These situations occur (1) when new specialty societies are granted representation to the HOD, and (2) when specialty societies lose representation in the HOD.

Additionally, during review of AMA policy in conjunction with this report, the Council has determined that, pending bylaws changes to enact the new delegate allocation system, the following AMA policies should be reviewed and may require action to reflect these changes: G-600.021, G-600.023 and G-600.135. These policy changes can be addressed following necessary bylaws changes, as the new apportionment mechanism will not come into effect until January 2018.

**Apportionment when Specialty Societies Gain or Lose Representation in the HOD**

Per section 8.4.2 of the AMA Bylaws, any eligible specialty society seeking representation in the HOD will submit an application through the AMA to the Specialty and Service Society (SSS) for consideration. These societies must submit their letters of application and supporting data for SSS review in November, at which point SSS will determine whether those societies have met the criteria for representation. The SSS makes its recommendations to the Board of Trustees (BOT) the following spring and to the HOD at that year’s Annual Meeting in June. The final decision to admit these societies is determined by the voting process of the HOD, and societies whose applications are accepted gain representation immediately.

Since apportionment of delegates occurs each year in January, and remains in effect for the entire year, per section 2.1.1 of the AMA Bylaws, delegate allocation necessarily takes place after the SSS has determined which, if any, specialty societies have met the criteria for representation, but before those societies are formally admitted to the HOD. CLRPD believes the most prudent method of allocating delegates to these societies is to apportion their delegates in January in anticipation of
their formal admittance at the subsequent Annual Meeting. Should the HOD decline to admit a specialty society, the delegate seat(s) apportioned to those societies should remain vacant for the duration of the year.

The inverse of this situation occurs when specialty societies fail to meet requirements for continued representation in the HOD set forth by AMA Bylaws and do not retain representation in the HOD. Such situations may occur at any meeting of the HOD. CLRDP recommends handling these situations in a similar fashion. In cases where specialty societies lose representation in the HOD, the delegate seat(s) that were apportioned to those societies in January of that year should remain vacant for the duration of the year.

These procedures will ensure equal apportionment of delegates to specialty and constituent societies each January, as called for by Policy G-600.027. They will also ensure that the maximum possible number of specialty society delegates will be apportioned for any given year; when new specialty societies are admitted to the HOD, the total number of specialty society delegates will not exceed the number of delegates apportioned to constituent societies. Additionally, research of previous meetings of the AMA HOD failed to uncover instances in which the HOD voted not to admit specialty societies recommended for representation by the SSS. Therefore, the only situations likely to result in a minor shortage of specialty society delegates (in relation to constituent society delegates) at any given meeting will occur if specialty societies lose representation in the HOD. Thus, these procedures will also guarantee that the most accurate possible number of specialty society delegates will be apportioned each year.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that AMA Policy G-600.027 be amended by addition to read as follows and the remainder of the report be filed:

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process:

   (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof.

   (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

   (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.
(i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(iii) In the case of a tie, the previous year’s data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.

3. The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.

4. This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.

5. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year. (Modify Current HOD Policy)

Fiscal Note: Less than $500
Whereas, The American Medical Association advances quality patient care, advocates for patients and promotes physician leadership; and

Whereas, Not-for-profit and for-profit healthcare corporations, organizations and other entities provide medical services, insurance, information technology services, devices, pharmaceutical products and other products and services that contribute close to 20% of the United States Gross Domestic Product; and

Whereas, Health organization governance boards are comprised of leaders who are ultimately responsible to establish the policies, make the strategy and oversee the activities and the performance that determine healthcare value; and

Whereas, Health organization boards select the Chief Executive Officer and monitor his or her progress¹; and

Whereas, There is significant evidence that the participation of physicians in the governance of many healthcare organizations is associated with higher business performance²,³, clinical quality⁴,⁵ and social outcomes⁶; and

Whereas, Physicians have special expertise with complex clinical outcomes data, can add to a board’s cognitive diversity, have a reputation for altruism and can offer special competitive insights⁷; therefore be it

RESOLVED, That our American Medical Association advocate for and promote the membership of actively practicing physicians on the boards of healthcare organizations including, but not limited to, acute care providers; insurance entities; medical device manufacturers; and health technology service organizations (New HOD Policy); and be it further

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RESOLVED, That our AMA promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards (New HOD Policy); and be it further

RESOLVED, That our AMA provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 04/26/17
Whereas, Family immigration detention is a system that detains and seeks to deport parents (most often the mother) and children who come to the United States to seek safe-haven (defined by the U.S. Citizenship and Immigration Services as the temporary refuge given to migrants who have fled their countries of origin to seek protection or relief from persecution or other hardships, until they can return to their countries safely or, if necessary until they can obtain permanent relief from the conditions they fled); and

Whereas, The detrimental impact of detention on both children and their parents, as well as the trauma of family separation, both have been well-documented, and

Whereas, Advocates and medical professionals have documented that detained families have limited access to reliable medical services and psychiatric care; and

Whereas, Medications are confiscated from detainees, but detainees are not screened for medical conditions or illnesses, including the need for emergency care, and do not have access to medical professionals; and

Whereas, A considerable proportion of detained mothers—80%, according to some estimates—were victims of sexual assault or rape on the journey to the United States and have had no opportunity for medical examination or treatment while detained; and

Whereas, Women and girls, including victims of rape or sexual assault, transferred to Immigration and Customs Enforcement custody family immigration detention centers have limited access to gynecological care; and

Whereas, The Department of Homeland Security (DHS) has no minimum age limit at which children can be held in detention; and

Whereas, Children in detention experience high rates of anxiety, depressive symptoms, and Post Traumatic Stress Disorder; and

Whereas, These children continue to experience distress including symptoms of depression and anxiety, sleep problems, difficulty eating, and behavioral issues, even after release; and

Whereas, The vast majority of detained families ultimately pass their credible fear interviews and are released; and
Whereas, Families released from detention may seek treatment not only for the mental and physical consequences of the violence and persecution that forced them to flee from their home countries, but also from the physical and psychological trauma they may have experienced while in detention; and

Whereas, The DHS Advisory Committee on Family Residential Centers recommended that DHS end family immigration detention as it was deemed unnecessary; and

Whereas, The DHS Advisory Committee’s report also voiced concerns over the inherent psychological and physical distress of detention, particularly for children; and

Whereas, Current AMA policy focuses only on addressing health care issues regarding detention as it relates to the criminal justice system and not with regard to immigration-related detention; therefore be it

RESOLVED, That our American Medical Association oppose the detention of families seeking safe haven (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the expansion of family immigration detention in the United States (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the separation of parents from their children who are detained while seeking safe haven (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for access to comprehensive health care for women and children in immigration detention. (New HOD Policy)

Fiscal note: Minimal – less than $1,000

Received: 04/27/17

RELEVANT AMA POLICY:

Youth Incarceration in Adult Facilities H-60.916
1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records. 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that “an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used.”
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care; (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior. (3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided. (4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

Financial Impact of Immigration on American Health System D-160.988

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

References

Whereas, American Medical Association Policy H-295.878 addresses Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education, which promotes education among the medical community; and

Whereas, AMA Policy H-65.976 addresses the Nondiscriminatory Policy for the Health Care Needs of LGBT Populations; and

Whereas, H-295.879 addresses Improving Sexual History Curriculum in Medical School; and

Whereas, The AMA holds 36 distinct policies on LGBTQ issues; and

Whereas, The AMA focuses on correct education and understanding of medical issues and policy; gender, is currently incompletely understood as a binary selection; and

Whereas, An individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other; and

Whereas, Variations in hormone receptors and hormones widen the scope of social understanding of gender, identity, and the continuum; therefore be it

RESOLVED, That our American Medical Association partner with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity as a complex interplay of gene expressions and biologic development. (Directive to Take Action)

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

Received: 04/28/17
Whereas, The term “quarantine” is broadly defined as (1) a strict isolation imposed to prevent the spread of disease; (2) a period, originally 40 days, of detention or isolation imposed upon ships, persons, animals on arrival at a port (or place) when suspected of carrying some infectious or contagious disease, (3) a system of measures maintained by governmental authorities for the prevention of a disease; and

Whereas, A quarantine separates and restricts the movement of people who could have been exposed to a contagious disease; and

Whereas, Quarantine stations are currently located at 20 ports of entry and land-border crossings where international travelers arrive; and

Whereas, These stations are staffed with quarantine medical and public health officers from the Centers for Disease Control and Prevention (CDC); and

Whereas, These health officials decide whether possibly contagious individuals can enter the United States and what measures should be taken to prevent the spread of infectious diseases; and

Whereas, On January 19, 2017, the CDC issued new regulations that gave it broad authority to quarantine individuals; and

Whereas, These regulations outline how the federal government can restrict interstate travel during a health crisis, and establishes in-house oversight (with up to three layers of internal agency review) of whether someone should be detained, without providing a clear and direct path to challenge a quarantine order; and

Whereas, This internal review has no explicit time limit and could easily stretch on for weeks (and months) while a “possibly” healthy person remains in quarantine; and

Whereas, until now, most quarantines have been imposed by states and local governments, which have the primary responsibility for protecting the health of their population; and

Whereas, The new administration now has even more authority to detain people; and

Whereas, Prompt judicial review has always been important during an epidemic, usually allowing people to challenge an order of quarantine; and
Whereas, The CDC now has clear authority to take over the quarantine role from states; and

Whereas, Quarantine regulations are now being imposed based in part, on non-medical reasons, rather than scientific knowledge and findings, therefore, be it

RESOLVED, That our American Medical Association adopt policy acknowledging that government quarantines are developed based on evidence-based medicine and have strong due process protections (New HOD Policy); and be it further

RESOLVED, That our AMA support that the medical profession collaborate with federal, state and local public health officials to take an active role in ensuring that quarantine and isolation interventions are evidence based. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17
Whereas, The automatic suspension of a patient’s do-not-resuscitate order is commonly practiced in operating rooms across the United States and the automatic suspension of a do-not-resuscitate order in the perioperative period undermines patients’ rights and the ethical principle of autonomy; and

Whereas, The Patient Self-Determination Act of 1990 requires health care institutions to provide patients with information regarding advance directives and patients’ rights to accept or refuse medical treatment; and

Whereas, The American Society of Anesthesiologists, the American College of Surgeons, and the Association of Operating Room Nurses support “required reconsideration” of patients’ existing advance directives in the perioperative period to support the review of patients’ advance directives prior to the performance of a procedure/surgery and the administration of anesthesia; and

Whereas, The Joint Commission requires that policies are present to uphold the respect of patients who refuse resuscitation; therefore be it

RESOLVED, That our American Medical Association adopt as policy the “required reconsideration” of patients’ existing advance directives in the perioperative period, in order to support the review of a patient’s advance directive prior to the performance of a procedure/surgery and the administration of anesthesia. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/01/17
Whereas, More than 3 million refugees have resettled in the United States since 1975, including approximately 85,000 in 2016 alone;¹,² and

Whereas, The prevalence of chronic diseases such as diabetes, heart disease, hypertension, and stroke in refugee populations is high (24.7% among 490 refugees in the 2003 New Immigrant Survey Adult Sample), but almost half of refugees with chronic conditions are uninsured, increasing their risk for poor health outcomes and limiting their access to needed care;³,⁴ and

Whereas, Refugees to the United States who meet financial eligibility criteria, but are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) can receive up to eight months of federally-funded healthcare under the Refugee Medical Assistance (RMA) program;⁵ and

Whereas, Refugees are exempt from the five-year bar for most “qualified non-citizen” immigrants to receive Medicaid and CHIP, are able to purchase qualified health plans from the Health Insurance Marketplace created by the Affordable Care Act (ACA), and may qualify for tax credits to obtain health insurance through the Marketplace;⁶ and

Whereas, In states with Medicaid expansion, the vast majority of refugees qualify for Medicaid, but Medicaid requires recertification of eligibility for benefits every six to twelve months, and immigrant families are often forced to re-apply after failing to recertify and having their Medicaid coverage terminated;⁷,⁸ and

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⁵ Office of Refugee Resettlement, HHS. Refugee Resettlement Program; Requirements for Refugee Cash Assistance; and Refugee Medical Assistance. Federal Register. 2000;65(56):42.
⁷ U.S. Committee for Refugees and Immigrants. Study of Domestic Capacity to Provide Medical Care For Vulnerable Refugees. 2015.
Whereas, In states without Medicaid expansion, refugees have a much smaller chance of receiving continued insurance after their eight-month post-arrival period as a result of restrictive eligibility criteria, and forty percent of refugees are resettled in such a state;\(^7,^9\) and

Whereas, Surveys of refugees indicate that among the most significant barriers to receiving access to healthcare are linguistic, literacy, and cultural challenges, unfamiliarity with health and social services programs, the complexity of the application process, and difficulties with navigating the healthcare system;\(^6,^10,^11\) and

Whereas, While the ACA requires medical language interpreter services in any county where there is a language group represented at levels higher than 10% of the total population, refugee populations may not be settled in large enough numbers to reach the threshold;\(^7\) and

Whereas, A pilot program in Rochester, New York instituted the addition of a consent form to the immigration paperwork required of refugees to allow the State to send a Medicaid recertification application to the nearest hospital, enabling continuous Medicaid coverage;\(^12\) and

Whereas, Current AMA policy recognizes the unique health needs of refugees and supports legislation and policies addressing these needs (H-350.957); therefore be it

RESOLVED, That our American Medical Association support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000
Received: 05/02/17

RELEVANT AMA POLICY:

Addressing Immigrant Health Disparities H-350.957 – 1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

Increasing Detection of Mental Illness and Encouraging Education D-345.994 – 1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers. 2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

See also:
Physicians Response to Victims of Human Trafficking H-65.966
Retraining Refugee Physicians H-200.950
Monitoring Medicaid Managed Care H-290.985
Make Simplicity the Foremost Criteria for Any CMS Program H-155.956

\(^12\) NYSHealth. Opening Doors: A Sustainable Refugee Health Care Model. NYS Health Foundation. 2016.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-17)

Introduced by: Minority Affairs Section

Subject: Healthcare as a Human Right

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael B. Hoover, MD, Chair)

Whereas, The United States of America voted in favor of the United Nations General Assembly’s Universal Declaration of Human Rights (UDHR) in 1948, and ratified each amending covenant that together constitute the encompassing International Bill of Human Rights; and

Whereas, Article 25 of the UDHR states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including…medical care”; and

Whereas, The United States is also a member state of the World Health Organization (WHO), which exhorts all member states to “contribute to meeting the needs of the population for health care”; and

Whereas, The United States makes good on these promises via Medicare and Medicaid programs, which provide basic levels of medical care for certain vulnerable and low-income American citizens; and

Whereas, The 115th Congress of the United States has proposed to withdraw the United States from both the United Nations and the World Health Organization, endangering these commitments; and

Whereas, The 115th Congress of the United States is currently discussing switching the open entitlement of Medicaid to a per capita or block grant system, which would limit states’ ability to care for Medicaid populations should healthcare costs or eligible populations increase; and

Whereas, The AMA has repeatedly endorsed the World Medical Association’s Declaration of Tokyo, which amongst other principles establishes that “A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician’s fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose” (H-65.997, H-65.991); and

Whereas, The WMA Declaration of Tokyo further encourages lifelong education on and furtherance of human rights by physicians and calls on all national medical associations to promote these endeavors; and

Whereas, The AMA recognizes that its conduct serves a model for health organizations around the globe, and that participation in these organizations is essential to achieving the AMA’s goals for public health (G-630.070); and

Whereas, The AMA supports continued funding of the World Health Organization and participation in international medical organizations (H-250.986, H-250.999, H-250.992); and
Whereas, The AMA has codified a physician’s duty to care for, advocate on behalf of, and endeavor to improve future care for all persons, making no exceptions for gender, socioeconomic status, race, origin, or creed (ex. H-140.900, H-140.997, H-140.838, H-160.975, H-140.951); and

Whereas, The AMA recognizes socioeconomic factors and self determination as important components of an individual’s health (ex. H-295.874); and

Whereas, An entire body of AMA policy exists under the heading “Civil and Human Rights” with the specific intent to support and define the fundamental concepts of human rights (ex. H-65.997); and

Whereas, The AMA has not yet specifically named healthcare as one such right; and

Whereas, The very mission statement of the AMA is “to promote the art and science of medicine and the betterment of public health”; therefore be it

RESOLVED, That our American Medical Association recognize that a basic level of medical care is a fundamental human right (New HOD Policy); and be it further

RESOLVED, That our AMA support the United Nations’ Universal Declaration of Human Rights and its encompassing International Bill of Human Rights as guiding principles fundamental to the betterment of public health (New HOD Policy); and be it further

RESOLVED That our AMA advocate for the United States to remain a member state in the World Health Organization. (New HOD Policy)

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

Received: 05/03/17

References:


RELEVANT AMA POLICY

Human Rights H-65.997; Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights H-65.991; International Strategy G-630.070; AMA and Public Health in Developing Countries H-250.986; World Health Organization H-250.999; World Health Organization H-250.992; Collaborative Care H-140.838; A Declaration of Professional Responsibility H-140.900; Professionalism and Medical Ethics H-140.951; Patient Advocacy H-140.997; Planning and Delivery of Health Care Services H-160.975; AMA Principles for Physician Employment H-225.950; Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Whereas, Biological sex, gender identity, and sexual orientation are separate categories; and

Whereas, Patient intake forms often only have “male” or “female” and occasionally “other” as selection options; and

Whereas, There are an estimated 700,000 transgender individuals in America, not accounting for individuals who may identify as nonbinary, genderqueer, genderfluid, or otherwise gender-nonconforming; and

Whereas, Health care environments are often distressing for non-conforming individuals due to a lack of awareness regarding LGBTQIA identities, healthcare worker insensitivity, and/or patient intake forms which fail to accurately record a patient’s preferred name, appropriate pronoun, sex, and gender identity, all of which can cause an individual to delay or not seek out care at all; and

Whereas, Without appropriate and complete documentation, it can be difficult to identify what organs an individual may or may not have that may require preventative health screenings, e.g. a cervix in an individual who was born female but has medically, socially, but not surgically, transitioned to male and is documented to have a gender of male; and

Whereas, The Department of Health and Human Services has ruled that “providers participating in the EHR Incentive Programs will need to have certified health IT with the capability to capture SO/GI [sexual orientation/gender identity] to meet the CEHRT definition in 2018 and subsequent years” and that “certification does not require that a provider collect this information, only that certified Health IT Modules enable a user to do so;” and

Whereas, Cahill et al found that most patients understood the importance of collecting SO/GI information and were willing to answer these questions; therefore be it

RESOLVED, That our American Medical Association support the inclusion of a patient’s biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable), surrogate identifications in medical documentation and related forms in a culturally-sensitive manner. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17
RELEVANT AMA POLICY

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include “sexual orientation, sex, or gender identity” in any nondiscrimination statement.

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.
Whereas, The commercial sexual exploitation and sex trafficking of minors in the United States is a problem of grave concern, the scope of which is likely to be more pervasive than is currently known because it occurs at the margins of society and behind closed doors; and

Whereas, Over the past decade, the commercial exploitation and human trafficking of minors has received increasing attention from advocates, the media, academics, and policy makers, and increasing attention is being given to the role that physicians and other health care providers can play in helping to address the problem; and

Whereas, In 2013, the Institute of Medicine (IOM) and the National Research Council (NRC) issued a report calling for the following guiding principles to serve as a foundation for understanding and responding to commercial sexual exploitation and sex trafficking of minors:

1) commercial sexual exploitation and sex trafficking of minors should be understood as acts of abuse and violence against children and adolescents;
2) minors who are commercially sexually exploited or trafficked for sexual purposes should not be considered criminals; and,
3) identification of victims and survivors and any intervention, above all, should do no further harm to any child or adolescent; and

Whereas, Commercially exploited children and adolescents are often treated as criminals instead of victims despite some state laws recognizing juvenile sex trafficking as a form of reportable child abuse; and

Whereas, Physicians and other health care providers are in a unique position to help identify human trafficking victims and refer them to supportive and rehabilitative services when appropriate before they find themselves caught up in the juvenile justice system; and

Whereas, A number of factors limit the ability of physicians and other health care providers to recognize victims and intervene, including a need for more understanding of commercial sexual exploitation and sex trafficking of minors, disclosure by victims, potential and perceived complications related to mandated reporting, and a need for policies and protocols to assist health care professionals in assessing and treating victims and survivors; therefore be it

RESOLVED, That our American Medical Association support the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000
Received: 05/03/17
RELEVANT AMA POLICY

Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

Whereas, It is estimated that approximately 1.4 million adults living in the United States identify as transgender, representing 0.6% of the general population, with many going underreported, including minors; and

Whereas, Laws and other policies that restrict the use of public facilities based on biological gender place undo harm on the physical and social well-being and safety of transgender individuals; and

Whereas, There have been multiple examples of such policies being enacted on the state and local level, many focusing on the use of public restrooms and locker rooms; and

Whereas Transgender individuals living in states with discriminatory policies have statistically significant increases in mental health and psychiatric diagnoses; and

Whereas, 54% of responders in one study of transgender individuals report physical problems from avoiding bathrooms at work or in public, including dehydration, urinary tract infections, and kidney infections; and

Whereas, A review of literature regarding voluntary infrequent urinary voiding found increased risk of urinary tract infections, renal failure, and poor bladder functioning and impaired urodynamics; and

Whereas, Transgender teenagers and other minors are at particular risk of social, mental, and physical detriment by being forced to disregard their gender identity or to publicly identify as transgender due to these policies; and

Whereas, Transgender individuals are the victim of prejudice and discrimination in multifaceted ways, including other basic human services such as employment, education, health care, housing, transportation, places of public accommodation, police protection, courts, and government benefits programs, often in the form of physical or verbal abuses; and

Whereas, For example, the National Center for Transgender Equality notes that 29% of transgender homeless report being turned away from a shelter due to their transgender status and 22% of those who stayed at a shelter reported experiencing sexual assault from staff or other residents; and

Whereas, The standard of medical care for patients with gender dysphoria, supported by the AMA (H-185.927), includes total immersion and experience of life according to one’s gender identity; and
Whereas, The AMA “reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age” (H-65.965); therefore be it

RESOLVED, That our American Medical Association oppose policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity. (Directive to Take Action)

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

Received: 05/03/17

References:

RELEVANT AMA POLICY

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995

School Violence D-515.997
Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation or gender identity, and similar behaviors and attitudes. CSAH Rep. 11, I-99 Modified: BOT Rep. 11, A-07

See also:
H-60.919 Juvenile Justice System Reform
H-65.965 Support of Human Rights and Freedom
H-65.976 Nondiscriminatory Policy for the Health Care Needs of LGBT Populations
H-65.979 Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth Organization
H-65.983 Nondiscrimination Policy
H-160.991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations
H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria
Whereas, Collaborative Institutional Training Initiative (CITI) certification to perform research was created to protect patients from harm and protect patient privacy; and

Whereas, Certification to perform research is expensive ($3,500-4,000) per researcher every two years and time-consuming requiring 6-10 hours of on-line studying and testing, and is required for publication of articles and abstracts and case submissions to journals; and

Whereas, Many journal articles are “off-the-shelf” existing retrospective reviews of patients treated by physicians or groups of physicians with none of the data sets recording the identities of the patients, and have no potential for patient injury; and

Whereas, Institutional Review Boards (IRB) have interpreted their mandate as requiring IRB approval prior to collection of data, and refuse to grant “expedited review.” They often ignore the category 5 recommendation. Category 5 is defined as: “Research involving materials (data, documents, records, or specimens) that have been collected or will be collected solely for non-research purposes. Such data would qualify for “expedited review.” Records based research poses no more than minimal risk of harm or discomfort to the subjects; and

Whereas, CITI certification far exceeds the patient safety and privacy needs for which it was created and thereby precludes and disadvantages practitioners--who often lack institutional resources--from sharing their experience; and

Whereas, Physicians are trained to practice empirically and learn from their experience and share this knowledge with others, and compliance with rigid publication guidelines denies them the opportunity to advance medical knowledge; therefore be it

RESOLVED, Our American Medical Association study existing Collaborative Institutional Training Initiative standards, Institutional Review Board protocols and create recommendations that would simultaneously protect patients and permit physicians to easily participate in the dissemination of medical knowledge (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2017 Interim Meeting. (Directive to Take Action)

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

Received: 05/03/17
Whereas, The reliable, safe, high quality and efficient practice of medicine requires the highest ethical and professional standards of physicians; and

Whereas, In some circumstances, these goals can be undermined by physician conduct asserted to be “disruptive, intimidating or inappropriate”; and

Whereas, Such behavior results in detrimental effects on patient care and the collegiality of the healthcare team; and

Whereas, Without appropriate investigation or process, such conduct cannot be concluded to be per se unethical, unprofessional and require sanction; and

Whereas, The valid concerns of a physician’s conduct or behavior, without appropriate review, can be misinterpreted, causing he/she to be mischaracterized as “disruptive, intimidating or inappropriate”; and

Whereas, Our AMA\(^1\) and The Joint Commission\(^2\) have published reports describing and defining the “disruptive physician” as well as model bylaws describing an investigative process to assure a fair hearing before a physician’s behavior may be affirmed or sanctioned; and

Whereas, The “employed physician,” although a member of the medical staff and is otherwise compliant with hospital bylaws, such as credentialing, committee service, continuing education programs, etc., may not be eligible to have “disruptive conduct” investigated or reviewed through such process; and

Whereas, He/she may be dismissed from employment “for cause” as being a “disruptive physician” which carries a stigma and possible effect with future employment considerations; therefore be it

RESOLVED, That our American Medical Association actively educate state and specialty medical societies about the AMA Medical Staff Code of Conduct and promote its use (Directive to Take Action); and be it further

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\(^2\) AMA CEJA Report 3-1-09. Physicians with Disruptive Behavior.

\(^3\) Joint Commission Sentinel Event Alert, Issue 40, July 9, 2008.
RESOLVED, That our AMA advocate that, as participating members of their medical staffs, “employed physicians” be afforded the same right of review as non-employed physicians as regards an accusation that their conduct has been characterized as “disruptive, intimidating or inappropriate. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/09/17
Whereas, The United States Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategies (REMS) are mandatory risk management plans that use risk minimization strategies beyond the professional labeling to ensure that the benefits of certain prescription drugs outweigh their risks;¹ and

Whereas, Many REMS programs are designed to prevent fetal exposure to highly teratogenic drugs, including, but not limited to, isotretinoin, mycophenolate mofetil, thalidomide, macitentan, bosentan, lenalidomide, riociguat, and pomalidomide. For many of these drugs, enrollment in the respective REMS program is mandatory in order to access the drug;² and

Whereas, Many of these REMS programs mandate the classification of patients as one of the following: females of child-bearing potential (FCBPs), females not of child-bearing potential (FnCBPs), or males;¹,³,⁴ and

Whereas, A female of childbearing potential is defined as “a nonmenopausal female who has not had a hysterectomy, bilateral oophorectomy, or medically documented ovarian failure” further characterized by “permanent cessation of previously occurring menses… with documentation of hormonal deficiency;”³ and

Whereas, The transgender population is increasing with an estimated 1.4 million people in the United States (0.6% of the population) identifying as transgender;⁵ and

Whereas, The results of gender-affirming hormonal therapies in transgender men may be reversible and do not guarantee ovarian failure, and as such transgender men with retained uterus and ovaries may continue to have the ability to become pregnant;⁶ and

Whereas, REMS provider and patient information do not specifically mention the care or accommodation of transgender individuals;³,⁴ and

Whereas, Transgender individuals are effectively excluded from the classification system, particularly transgender men who possess the reproductive anatomy capable of producing a pregnancy, given that the current classification associates child-bearing potential exclusively with a designation of female gender identity;⁹⁻¹¹ and
Whereas, The inability of transgender individuals to register in REMS programs in a manner commensurate with their gender identity while also accurately stating their childbearing potential creates a barrier to care with perpetuation of cultural insensitivity, in many cases resulting in deferral of otherwise indicated treatment;9-11 and

Whereas, The current categorization scheme poses an ethical conflict for physicians caring for transgender patients, necessitating a choice between affirming a patient’s gender identity and providing an accurate evaluation of childbearing potential;9-11 and

Whereas, Both the Institute of Medicine and The Joint Commission have called for increased awareness of healthcare disparities in the gender minority community as well as stigma reduction;12,13 therefore be it

RESOLVED, That our American Medical Association work with the United States Food and Drug Administration to develop a gender-neutral patient categorization model in Risk Evaluation and Mitigation Strategies programs, focusing exclusively on childbearing potential rather than gender identity. (Directive to Take Action)

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

Received: 05/11/17

References:

RELEVANT AMA POLICY

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families
H160.991 Health Care Needs of Lesbian, Gay, Bisexual, and Transgender Populations
D-100.971 Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation
H-100.961 The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)
Whereas, Existing AMA Policy H-270.965, “Physician-Assisted Suicide.” is clear that “our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer” and H-140.952, “Physician Assisted Suicide,” which states that “Physician Assisted Suicide is fundamentally inconsistent with the physician’s professional role; and

Whereas, A review of all AMA policy yields no results for the phrase ‘aid in dying’, especially in any way meant to be synonymous with ‘physician assisted suicide’; and

Whereas, The replacement of the use of the known phrase ‘physician assisted suicide’ with the new phrase ‘aid in dying’ will have and is having the effect of concealing the reality of the fact that both these phrases are being used interchangeably to refer to the same specific defined procedure long established and defined already to be ‘physician assisted suicide’; and

Whereas, ‘Physician assisted suicide’ is clearly defined to be a situation where a physician is asked to and agrees to prescribe a lethal dose of medication to a patient known to be terminally ill so that the patient can self-administer that lethal dose and bring about the immediate end of their own life; and

Whereas, There is no more clear and appropriate phrase to define this procedure than “Physician Assisted Suicide”; and

Whereas, AMA policy is often operationally meted out in the public sector and daily through the terms it endorses and advertises making its selection of terms and phrases like ‘physician assisted suicide’ or ‘aid in dying’ very important with regards to how we maintain transparency and clarity with regards to AMA policy positions; and

Whereas, Any attempt to re-brand what is clearly “physician assistance in the act of suicide” to what is felt to be a softer, less ‘inflammatory’, ‘aid in dying’, can be well-intended but can also have many unintended consequences; and

Whereas, Physicians may either agree or disagree on the ethics and propriety of assisted suicide, the change in terminology creates an insidious misrepresentation if not confusion about the reality of the ‘physician assisted suicide’ process and act which does not hold true to the transparency of the AMA’s current policy position; therefore be it
RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as ‘Physician Assisted Suicide’ avoid any replacement with the phrase ‘Aid in Dying’ when describing what has long been understood by the AMA to specifically be ‘Physician Assisted Suicide’ (New HOD Policy); and be it further

RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘Physician Assisted Suicide’ and the phrase ‘Aid in Dying’ (Directive to Take Action); and be it further

RESOLVED, That these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both ‘Physician Assisted Suicide’ and ‘Aid in Dying.’ (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Physician Assisted Suicide H-140.952
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.
Whereas, Transgender individuals sentenced to jail or prison time are often placed in facilities based on birth gender, unless they have undergone complete surgical transition. However, a 2012 report by the Department of Justice confirmed that transgender individuals placed in prisons inconsistent with their gender identity experience rape, harassment, and physical violence at higher levels than non-transgender prisoners (34% experienced sexual violence vs 10% for the overall population). Another study by UC-Irvine looking at assault in California prisons confirmed this increased risk with 59% of transgender prisoners experiencing sexual assault vs 4.4% of prisoners overall.

Whereas, Transgender prisoners are often placed in “administrative segregation” for “protection” from violence but this separation also excludes these prisoners from recreation, educational and occupational opportunities which may violate their constitutional rights. Additionally, transgender inmates are often denied hormonal therapy in prison, which can result in gender dysphoria and depression;

Whereas, A Bureau of Justice Statistics survey from Spring 2015 estimates that there were at least 3,209 transgender prisoners in state and federal facilities in 2011–2012, or about 0.22% of the national prison population, according to the National Center for Transgender Equality calculations. The Justice Bureau estimated there were 1,709 transgender inmates in local jails, or about 0.23% of the national jail population;

Whereas, More significantly, nearly one in six transgender Americans and nearly half of all transgender black Americans have been to prison so that transgender people as a population are significantly impacted by prison policies; and

1 Transsexual people who have not had genital surgery are generally classified according to their birth sex for purposes of prison housing, regardless of how long they may have lived as a member of the other gender, and regardless of how much other medical treatment they may have undergone”, Farmer v. Brennan, 511 U.S. 825, 829 (1994); Farmer v. Haas, 990 F.2d 319, 320 (7th Cir. 1993)
2 Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012; Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; Allen Beck, Ph.D., statistician.
3 Violence in California Correctional Facilities: an Empirical Examination of Sexual Assault; Criminology, Law and Society, University of California-Irvine, Center for Evidence Based Corrections; April 27, 2007.
6 RH reality check, “Sentenced to Abuse: Trans People in Prison Suffer Rape, Coercion, Denial of Medical Treatment”, May 12, 2015
Whereas, The Department of Justice issued a statement in April 2015 stating that all prisoners should be treated adequately for any gender dysphoria\(^8\); and current AMA policy exists to support gender affirmation of transgender individuals regardless of surgical status (AMA Policy H-65.967). All prisoners, regardless of gender identity, deserve access to health care and safety while incarcerated; therefore be it

RESOLVED That our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967

1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.
2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.


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