**Handbook Review: HOD Reference Committee on Amendments to Constitution and Bylaws**


<table>
<thead>
<tr>
<th>HOD resolution or report (sponsor)</th>
<th>Action requested</th>
<th>AMA-WPS recommended position</th>
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<tbody>
<tr>
<td>BOT Report 5: Effective Peer Review</td>
<td>RECOMMENDATIONS The Board of Trustees recommends that the following be adopted per AMA Policy D-375.987, and that the remainder of the report be filed:</td>
<td>Support</td>
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<td>1. That AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” be amended by addition as follows:</td>
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<td>. . . IV. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy);</td>
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<td>2. That AMA Policy H-375.962, “Legal Protections for Peer Review,” be amended by addition as follows:</td>
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<td>. . . Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. (Modify Current HOD Policy); and</td>
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<td>3. That our AMA will provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies. (Directive to Take Action)</td>
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<td>Fiscal Note: $5000</td>
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<td>BOT Report 7: Medical Reporting for Safety-Sensitive Positions (Resolution 14-A-16)</td>
<td>RECOMMENDATION In light of these considerations, the Board of Trustees recommends that the following be adopted and the reminder of this report be filed:</td>
<td>Monitor</td>
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<td>1. That our American Medical Association (AMA) promote awareness among all licensed physicians of the safety implications of mental health and other potentially impairing conditions for their patients who are aviator. Physicians need to be aware that for some patients the FAA’s BasicMed program now makes the treating physician a gatekeeper for pilot and public safety. Physicians who are not FAA Aviation Medical Examiners should be educated about when to seek guidance from colleagues with aeromedical</td>
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<tr>
<th>RECOMMENDATIONS</th>
<th>Support</th>
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<tr>
<td>1. That our AMA urge physicians to screen routinely for factors that may compromise pilot safety by the least intrusive means reasonable and take steps with the patient to mitigate identified risks. Physicians should be encouraged to consult with or refer the patient to the appropriate FAA Aviation Medical Examiner or FAA Regional Flight Surgeon. (New HOD Policy)</td>
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<td>2. That our AMA advocate for adoption of a uniform mechanism for reporting aviators who have potentially compromising medical conditions. (New HOD Policy)</td>
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<td>3. That the Council on Ethical and Judicial Affairs be encouraged to review implications for existing ethics guidance in light of the FAA’s alternative requirements for pilot physical examination and education codified in BasicMed. (New HOD Policy)</td>
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<td>Fiscal Note: Less than $1000</td>
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*CCB Report 1: Amended Bylaws – Specialty Society Representation – Five-Year Review*
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<tr>
<th>Section</th>
<th>Description</th>
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<td>8.5.1</td>
<td>If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.</td>
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<td>8.5.2</td>
<td>If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.</td>
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<td>8.5.3</td>
<td>Another review of the specialty society’s or the professional interest medical association’s compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.</td>
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<td>8.5.3.1</td>
<td>If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed. The next review will occur four years from the time of the House’s action to continue representation.</td>
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<td>8.5.3.2</td>
<td>If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may must take one of the following actions:</td>
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### 8.5.3.2.1 The House of Delegates may continue the representation of the 2 specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1. The next review will occur four years from the time of the House’s action to continue representation after a one-year grace period.

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

### *CEJA* Report 1: Competence, Self-Assessment and Self-Awareness

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

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

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

| Support |
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<tr>
<th>CEJA Report 2: Ethical Physician Conduct in the Media</th>
<th>RECOMMENDATION</th>
<th>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.</th>
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<td>to provide appropriate care for the patient in front of them or the patients in their practice as a whole.</td>
<td>To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:</td>
<td>(a) Exercise continuous self-awareness and self-observation;</td>
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<td>(b) Recognize that different points of transition in professional life can make different demands on competence;</td>
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<td>(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations;</td>
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<td>(d) Seek feedback from peers and others;</td>
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<td>(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest. Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.</td>
<td>(New HOD/CEJA Policy)</td>
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Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:

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

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

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

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

   (i) accurate
   (ii) inclusive of known risks and
   (iii) commensurate with their medical expertise
   (iv) based on valid scientific evidence and insight gained from professional experience

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

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

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

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<tr>
<th>CEJA Report 3: Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Resolution 3-A-16)</th>
<th>RECOMMENDATION</th>
<th>Active Support</th>
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<td><strong>RECOMMENDATION</strong> The Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, &quot;Pediatric Decision Making,&quot; be amended as follows in lieu of Resolution 3-A-16 and the remainder of this report be filed:</td>
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<td>Unlike health care decisions for most adult patients, decisions for pediatric patients usually involve a three-way relationship among the minor patient, the patient’s parents (or guardian), and the physician. Although children who are emancipated may consent to care on their own behalf, in general, children below the age of majority are not considered to have the capacity to make health care decisions on their own. Rather, parents or guardians are expected, and authorized, to provide or decline permission for treatment for minor patients. Nonetheless, respect and shared decision making remain important in the context of decisions for minors. Physicians have a responsibility to support the child’s emerging autonomy and should engage minor patients in making decisions about their own care to the greatest extent possible, including decisions about life-sustaining treatment.</td>
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<td>Decisions made for pediatric patients should seek to foster the well-being of children patients and the adults they will become. Physicians should provide information and other resources to support parents or guardians in making decisions about their child’s care and should individualize treatment to promote the child’s best interest, which is determined by weighing many factors, including effectiveness of available appropriate medical therapies and the needs and interests of the patient and the family as the source of support and care for the patient.</td>
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<td>Parents or guardians must also assess whether the decision made for a minor patient will abrogate a choice the future individual would want to make for him- or herself. Except when immediate treatment is medically necessary to preserve life or avert serious and irreversible harm, physicians should support parents’ efforts to make decisions that do not undermine the child’s right to an “open future.” When there is legitimate inability to reach no consensus in the field about what is in the best interest of the child, the wishes of the parents/guardian should generally receive preference.</td>
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For health care decisions involving minor patients, physicians should:

(a) Involve all patients in decision making at a developmentally appropriate level.

(b) Base recommendations for treatment on the likely benefit to the patient, taking into account the effectiveness of treatment, risks of additional suffering with and without treatment, available alternatives, and overall prognosis as indicated by the best available scientific evidence. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify the value to patients of different approaches to care.

(c) For patients capable of assent, truthfully explain the medical condition, its clinical implications, and the treatment plan in a manner that takes into account the child’s cognitive and emotional maturity and social circumstances for patients capable of assent.

(d) Provide a supportive environment to promote the well-being of both the patient and the family and encourage parents to discuss their child’s health status with the patient. Offer to facilitate the parent-child conversation for reluctant parents.

(e) Recognize that for certain medical conditions, such as those involving HIV/AIDS, or inherited conditions, or developmental anomalies, may involve highly sensitive information. Disclosing the child’s health status may also reveal health information about biological relatives, or disrupt relationships within the family, or lead to stigma or discrimination. Physicians should offer education and support to help minimize the psychosocial impact of such conditions for the child and the family.

(f) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents in ways to avoid behaviors that put the child or others at risk.

(g) Ensure that when decisions involve life-sustaining interventions, ensure that patients have opportunity to be involved in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardian understand the patient’s diagnosis, both with and without treatment. Physicians should discuss with the patient and parents/guardian the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a specified amount of time to determine if it has led to
improvement. Confirm that if the intervention has not achieved agreed-on goals it may be withdrawn.

(h) Respect the decisions of the patient and parents/guardian when it is not clear whether a specific intervention promotes the patient’s best interests.

(i) Seek consultation with an ethics committee or other institutional resource when:

(i) there is a reversible life-threatening condition and the patient (if capable) or parents/guardian refuse treatment the physician believes is clearly in the patient’s best interest; or

(ii) there is disagreement about what the patient’s best interests are. Physicians should turn to the courts to resolve disagreements only as a last resort.

(j) Provide compassionate and humane care to all pediatric patients, including patients who forgo or discontinue life-sustaining interventions.

(Modify Current HOD/CEJA Policy)

Fiscal Note: Less than $500

*CEJA Report 4: Mergers of Secular and Religiously Affiliated Health Care Institutions

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

1. That Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a Physician’s Ability to Provide Patient Centered, Safe Care Services,” be rescinded. (Rescind HOD Policy)

2. That the following be adopted, and the remainder of this report be filed:

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

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

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

(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the range of services previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same range of services remains available in the community.

(d) Recognize that physicians’ primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

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

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

(New HOD/CEJA Policy)

Fiscal note: Less than $500
### Resolution 001: Disaggregation of Data Concerning the Status of Asian-Americans

**Introduced by:** Medical Student Section

**Resolved:** That our American Medical Association support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (New HOD Policy)

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

**Recommended Position:** Support

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### Resolution 002: Intimate Partner Violence Policy and Immigration

**Introduced by:** Women Physicians Section

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

**Resolved:** That our AMA work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status. (Directive to Take Action)

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

**Recommended Position:** Active Support

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### Resolution 003: Revision of AMA Policy Regarding Sex Workers

**Introduced by:** GLMA

**Resolved:** That our American Medical Association amend the text of HOD Policy H-20.898, “Global HIV/AIDS Prevention,” by addition and deletion to read as follows:

H-20.898 Global HIV/AIDS Prevention
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution sex work (Modify Current HOD Policy); and be it further

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

H-20.922 HIV/AIDS as a Global Public Health Priority
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with
Medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;

(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;

(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;

(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;

(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;

(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes commercial sex;

(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and

(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.

(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of “treatment as prevention,” and the need for linkage of newly HIV-positive persons to clinical care and partner services (Modify Current HOD Policy); and be it further

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

H-515.958 Promoting Safe Exit from Prostitution Sex Work
Our American Medical Association supports efforts to offer individuals opportunities to a safe exit from prostitution sex work safely if they choose to do so, as well as access to in pursuit of compassionate care and “best practices”-based services whether or not they choose to continue in sex work. Our American Medical Association also and supports legislation for programs that prevent provide alternative employment to
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<th>Resolution 004: Tissue Handling</th>
<th><strong>RESOLVED,</strong> That our American Medical Association adopt policy stating that fetal tissue obtained during the termination of a pregnancy should be handled no differently than other tissues obtained during a medical procedure (New HOD Policy); and be it further RESOLVED, That our AMA strongly oppose any proposed laws or regulations that would require the handling of fetal tissue obtained during the termination of a pregnancy differently than other tissues obtained during a medical procedure. (Directive to Take Action) Fiscal Note: Minimal - less than $1,000</th>
<th>Active Support with amendment</th>
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<td>Introduced by: Michigan</td>
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*Resolution 005: Protection of Physician Freedom of Speech*  
Introduced by: American Academy of Pain Medicine

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<th>Resolution 005: Protection of Physician Freedom of Speech</th>
<th><strong>RESOLVED,</strong> That our American Medical Association strongly oppose litigation challenging the exercise of a physician’s First Amendment right to express good faith opinions regarding medical issues (New HOD Policy); and be it further RESOLVED, That our AMA’s House of Delegates encourage the AMA Litigation Center to provide such support to a constituent or component medical society whose members have been sued for expressing good faith opinions regarding medical issues as the Litigation Center deems appropriate in any specific case. (New HOD Policy) Fiscal Note: Minimal - less than $1,000</th>
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| Resolution 006: Physicians' Freedom of Speech | **RESOLVED,** That our American Medical Association encourage the Council on Ethical and Judicial Affairs to amend Ethical Opinion 1.2.10, “Political Action by Physicians,” by addition to read as follows:  
E-1.2.10 Political Action by Physicians  
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients and community health. However, they have a responsibility to do so in ways that are not disruptive to patient care. | Monitor |
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<td>Introduced by: Minority Affairs Section</td>
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Physicians who participate in advocacy activities should:
(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians’ primary and overriding commitment to patients.
(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

Furthermore, physicians:
(e) Should indicate they are expressing their personal opinions, which are guaranteed under the First Amendment of the U.S. Constitution, and should refrain from implying or stating that they are speaking on behalf of their employers;
(f) Should be allowed to express their personal opinions publicly without being subjected to disciplinary actions or termination. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

*Included in the Handbook Addendum
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