

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

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- 26 Research Handling of De-Identified Patient Information

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- 019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes
- 020# Changes to E-5.7, "Physician-Assisted Suicide"
- 021# Health, In All Its Dimensions, Is a Basic Right
- 022# Opposition to Involuntary Civil Commitment for Substance Use Disorder

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-A-19

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the
2 applications of the American Academy of Sleep Medicine and the American Society of
3 Cytopathology for national medical specialty organization representation in the American Medical
4 Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA
5 SSS Rules Committee and presented to the SSS Assembly for consideration.

6
7 The applications were considered using criteria developed by the Council on Long Range Planning
8 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

9
10 Organizations seeking admission were asked to provide appropriate membership information to the
11 AMA. That information was analyzed to determine AMA membership, as required under criterion
12 3. A summary of this information is attached to this report as Exhibit B.

13
14 In addition, organizations must submit a letter of application in a designated format. This format
15 lists the above-mentioned guidelines followed by each organization's explanation of how it meets
16 each of the criteria.

17
18 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.
19 Both organizations have actively participated in the SSS for more than three years.

20
21 Review of the materials and discussion during the SSS meeting at the 2018 Interim Meeting
22 indicated that the American Academy of Sleep Medicine and the American Society of
23 Cytopathology meet the criteria for representation in the HOD.

24
25 **RECOMMENDATION**

26
27 Therefore, the Board of Trustees recommends that the American Academy of Sleep Medicine and
28 the American Society of Cytopathology be granted representation in the AMA House of Delegates
29 and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500 to implement.

APPENDIX

Exhibit A

**GUIDELINES FOR REPRESENTATION IN & ADMISSION TO
THE HOUSE OF DELEGATES:**

National Medical 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.

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.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Sleep Medicine	1,202 of 5,185 (23%)
American Society of Cytopathology	286 of 1,371 (21%)

REPORT 26 OF THE BOARD OF TRUSTEES (A-19)
Research Handling of De-Identified Patient Information
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, Policy D-315.975, “Research Handling of De-Identified Patient Information,” was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to study the handling of de-identified patient data and report the findings and recommendations to the House of Delegates at the 2019 Annual Meeting. This report outlines appropriate and inappropriate use of de-identified patient data, perspectives from stakeholders in organized medicine, potential ethical concerns of the commercial use of such data, regulatory implications, and recommendations for the future use of de-identified patient data

Protected health information (PHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with patient health information. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Security of PHI safeguards patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment. However, the use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-19

Subject: Research Handling of De-Identified Patient Information

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, Policy D-315.975, “Research Handling of De-Identified Patient
4 Information,” was adopted by the House of Delegates. This policy directs the American Medical
5 Association (AMA) to study the handling of de-identified patient data and report the findings and
6 recommendations to the House of Delegates at the 2019 Annual Meeting. This report outlines
7 appropriate and inappropriate use of de-identified patient data, perspectives from stakeholders in
8 organized medicine, potential ethical concerns of the commercial use of such data, regulatory
9 implications, and recommendations for the future use of de-identified patient data.

10 BACKGROUND

11
12
13 Health-related information collected during the course of clinical care has always been of great
14 interest for a number of secondary use cases, including scientific research in the academic and
15 commercial settings, marketing for pharmaceutical and medical device companies, and a wide
16 variety of other uses. More recently, a new and substantial interest has been raised from technology
17 companies who seek to use patient data to build new clinical tools using machine learning and “big
18 data.” Clinical data is the topic of significant ethical guidance and regulation at both the state and
19 federal levels, focused primarily on the appropriate use and handling of identifiable patient
20 information. Little guidance exists, however, on the use of de-identified patient data.

21
22 A variety of entities, including provider organizations, clinical laboratories, and commercial
23 entities such as personal genomics companies, may collect patient data intended for clinical use or
24 to deliver genetics information, and then resell de-identified data to other entities for other
25 purposes. For example, 23andMe, a personal genomics and biotech service, sells de-identified user
26 data to pharmaceutical companies that use it to conduct research on various diseases. Concerns
27 arise in that when the data is de-identified, it is no longer considered PHI and therefore patient
28 authorization or consent for use is not required and therefore not solicited—meaning that patients
29 are not always aware how their data is being used.¹ For example, research using de-identified data
30 such as biologic specimens may result in scientific knowledge that has commercial value. Proper
31 consent for use and/or disclosure of commercial interest in this research is ideal but not always
32 documented, sometimes resulting in legal action against physicians or researchers.²

33
34 In addition, there is a perceived lack of transparency and regulation in how patients’ data is being
35 sold, distributed, or used outside of their direct health care. Risk of re-identification, which some
36 studies have demonstrated to be possible through matching data to other publicly available data
37 sources, is another issue related to the use of de-identified data. There are also concerns about

1 access to such information that is sought for marketing purposes on behalf of commercial entities
2 that have financial interests in physicians' treatment and/or prescribing behavior. In addition, the
3 sale of de-identified data by clinicians and provider organizations may create a real or perceived
4 conflict of interest, which could lead to a loss of patient confidence.

5 6 *What is Protected Health Information*

7
8 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides extensive
9 protections for patient data that is considered protected health information (PHI).³ PHI is
10 information, including demographic information, which relates to an individual's past, present, or
11 future physical or mental health or condition; the provision of health care to the individual; or the
12 past, present, or future payment for the provision of health care to the individual, and that identifies
13 the individual or for which there is a reasonable basis to believe can be used to identify the
14 individual.⁴ PHI includes many common identifiers (e.g., name, address, birth date, Social Security
15 Number) when they can be associated with the health information listed above. The HIPAA
16 Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such
17 information without patient authorization.⁵ Security of PHI safeguards patients from the risk of
18 their data being released or used in manners that could result in discrimination, stigmatization, or
19 embarrassment.^{6, 7} Section 164.514(a) of the HIPAA Privacy Rule establishes standards for de-
20 identifying PHI so individuals can no longer be identified by any portion of the data. The use, sale,
21 or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-
22 identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus,
23 may be used and disclosed by a covered entity or health information organization (HIO) for any
24 purpose.⁸

25
26 In addition to regulation at the federal level, state lawmakers have exhibited a general trend toward
27 establishing stricter guards on the use of patient data and the requirement for patient consent, some
28 of which reflect standards set forth in the European Union's recent General Data Protection
29 Regulation (GDPR).⁹ Some states are considering and passing laws to protect consumer privacy as
30 it relates to the use of their personal information. For example, California in June 2018 passed the
31 California Consumer Privacy Act of 2018 (effective January 1, 2020), which protects consumers'
32 right to: (1) know what personal information a for-profit business has collected about them, where
33 it was sourced from, what it is being used for, whether it is being disclosed or sold, and to whom it
34 is being disclosed or sold; (2) "opt out" of allowing a business to sell their personal information to
35 third parties; (3) have a business delete their personal information, with some exceptions; and (4)
36 receive equal service and pricing from a business, even if they exercise their privacy rights under
37 the Act.¹⁰ California's law does not apply to information covered by HIPAA, de-identified personal
38 data, or aggregate consumer data, however, as long as the de-identification measures meet the
39 Act's strict standards.¹¹

40 41 *What is de-identified patient data?*

42
43 De-identified patient data is information about a patient or user of a health-related service that has
44 been stripped of individually identifiable health information. Removing identifiers from PHI
45 mitigates privacy risks to individuals and thereby supports the secondary use of data for
46 comparative effectiveness studies, policy assessment, life sciences research, and other endeavors.⁴
47 Information can be de-identified by either of two means: (1) a formal determination by a qualified
48 expert (expert determination); or (2) the removal of specified individual identifiers and an absence
49 of actual knowledge by the covered entity that residual information could be used to identify the
50 individual (safe harbor).

51 The identifiers removed from PHI in the safe harbor method include:⁴

- 1
- 2 • Names
- 3 • All geographic subdivisions smaller than a state, including street address, city, county,
- 4 precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the
- 5 ZIP code if, according to the current publicly available data from the Bureau of the Census:
- 6 ○ The geographic unit formed by combining all ZIP codes with the same three initial
- 7 digits contains more than 20,000 people; and
- 8 ○ The initial three digits of a ZIP code for all such geographic units containing
- 9 20,000 or fewer people is changed to 000
- 10 • All elements of dates (except year) for dates that are directly related to an individual,
- 11 including birth date, admission date, discharge date, death date, and all ages over 89 and all
- 12 elements of dates (including year) indicative of such age, except that such ages and
- 13 elements may be aggregated into a single category of age 90 or older
- 14 • Telephone numbers
- 15 • Vehicle identifiers and serial numbers, including license plate numbers
- 16 • Fax numbers
- 17 • Device identifiers and serial numbers
- 18 • Email addresses
- 19 • Web URLs
- 20 • Social security numbers
- 21 • Internet Protocol addresses
- 22 • Medical record numbers
- 23 • Biometric identifiers, including finger and voice prints
- 24 • Health plan beneficiary numbers
- 25 • Full-face photographs and any comparable images
- 26 • Account numbers
- 27 • Any other unique identifying number, characteristic, or code, except as permitted
- 28 • Certificate/license numbers
- 29

30 *How is de-identified data used?*

31

32 De-identified data is used for research to derive information and knowledge about treatment and

33 outcomes, as well as other patient care-related purposes. Outside of health care organizations and

34 researchers, de-identified patient data is used by a variety of organizations and industries for

35 various purposes, including many not related to patient care. De-identified data is sourced,

36 collected, and used by a variety of organizations, including health care provider organizations such

37 as hospitals or academic medical centers, and commercial enterprises such as personal genomics

38 and biotechnology companies. Pharmaceutical manufacturers and retail pharmacies may also find

39 use in de-identified health data to target their advertising. Health care providers use this data

40 typically in research or the direct care of patient populations. The data can also be used to help

41 reduce costs of care, improve treatment options, and support public health initiatives.

42

43 Machine learning is a family of methods used by some health care and data solution organizations

44 to help predict certain outcomes and better prepare for and treat patients identified to be at risk.

45 Machine learning models establish predictive rules using vast amounts of computing power. The

46 more data a machine learning model has, the more complex the rules and the more accurate the

47 predictions.¹² However, machine learning models are vulnerable to biases induced by data that does

48 not adequately represent the patient population, such as data collected from only one institution or

49 one geographic region. In order to develop clinical decision support tools that can be effectively

50 used to treat the diverse patient populations in the United States, large amounts of data are

1 required, and often data from many different providers across the country are required to avoid
2 bias. This data is often sourced from de-identified or anonymized patient records. Allscripts, for
3 example, used 50 million de-identified patient records, and the application of an advanced machine
4 learning algorithm, to “train” its systems and further improve its clinical decision support tools.¹³
5 Organizations like Orion Health and Precision Driven Health are using datasets like these to
6 generate machine learning aimed at improving health care decisions, and driving operational and
7 cost efficiencies.^{12, 14} By combining multiple datasets, such as behavioral data, device use data,
8 patient claim data and socioeconomic and geographic data, these organizations are developing
9 advanced predictive analytics to further improve precision health care.¹⁴ The data used for the
10 purposes of data mining and honing machine learning algorithms are either sourced and used at the
11 organizational level, or de-identified or anonymized when used for external research, such as the
12 analysis done by Allscripts. Data may be sourced via publicly available de-identified datasets,
13 databases established through collaborative research agreements, or via the purchase of bulk de-
14 identified data, on an exclusive or non-exclusive basis. Since this technology is relatively new in
15 the health care space its implications for patient data are not well-studied. As artificial intelligence
16 and advanced machine learning proliferate in the health care space, the value and number of
17 potential uses of patient health data will inevitably increase. Stakeholders should be prepared for
18 increasing concerns about related patient privacy and data security.

19
20 Commercial entities, such as personal genomics companies, may collect data to deliver genetics
21 information to subscribers and then subsequently sell the de-identified data to another entity for
22 another purpose. For example, 23andMe, a genomics and biotech service, sells de-identified user
23 data to pharmaceutical companies that use it to conduct research on various diseases. Concerns
24 arise in that when the data is de-identified, it is no longer considered PHI and therefore patient
25 authorization or consent for use is not required and therefore not solicited—meaning that patients
26 are not always aware how their data is being used.¹ For example, research using de-identified data
27 such as biologic specimens may result in scientific knowledge that has commercial value. Proper
28 consent for use and/or disclosure of commercial interest in this research is ideal but not always
29 documented, sometimes resulting in legal action against physicians or researchers.²

30
31 In addition, there is a perceived lack of transparency and regulation in how patients’ data is being
32 sold, distributed, or used outside of their direct health care. Risk of re-identification, which some
33 studies have demonstrated to be possible through matching data to other publicly available data
34 sources, is another issue related to the use of de-identified data. There are also concerns about
35 access to such information that is sought for marketing purposes on behalf of commercial entities
36 that have financial interests in physicians’ treatment and/or prescribing behavior.

37 38 AMA POLICY

39
40 The AMA has multiple policies expressing its recognition of the importance of data privacy and
41 protection of PHI, as well as policies expressing commitment to ensuring safe and appropriate use
42 of de-identified data.

43
44 Board of Trustees Report 21-A-18, “Ownership of Patient Data,” outlines federal and state laws
45 that establish who owns a patient’s medical records. The report also highlights the importance of
46 ensuring patients have appropriate access to their data and physicians have the tools and controls
47 they need to be good stewards of their patients’ information while at the same time maintaining the
48 ability to share information to seamlessly coordinate the best care. In support of these initiatives,
49 the AMA has actively engaged with the U.S. Department of Health and Human Services (HHS),
50 the Office of Inspector General, the Office of Civil Rights, and the Office of the National

1 Coordinator for Health Information Technology (ONC), and has broad policy in place covering all
2 aspects of patient record maintenance, access and control.

3
4 AMA Policy H-315.978, "Privacy and Confidentiality," states that where possible, informed
5 consent should be obtained before personally identifiable health information is used for any
6 purpose. However, in those situations where specific informed consent is not practical or possible,
7 either (1) the information should have identifying information stripped from it or (2) an objective,
8 publicly accountable entity must determine that patient consent is not required after weighing the
9 risks and benefits of the proposed use. Re-identification of personal health information should only
10 occur with patient consent or with the approval of an objective, publicly accountable entity.

11
12 AMA Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical
13 Record Information," expresses the AMA's commitment to advocating that physicians, as trusted
14 stewards of PHI, should be the owners of all patient claims data and de-identified aggregate data
15 that is established and maintained by the physician practice, specifically including data stored in
16 the electronic health record or practice management system. The policy establishes principles
17 around the use of these data that include compliance with HIPAA, requires physician consent for
18 analysis of the data, and requires data to remain accessible to authorized users for purposes of
19 treatment, public health, patient safety, quality improvement, medical liability defense, and
20 research.

21
22 AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that whenever possible,
23 medical records should be de-identified for purposes of use for utilization review, panel
24 credentialing, quality assurance, and peer review. This policy also states our AMA will guard
25 against the imposition of unduly restrictive barriers to patient records that would impede or prevent
26 access to data needed for medical or public health research or quality improvement and
27 accreditation activities, and that whenever possible, de-identified data should be used for these
28 purposes. Policy H-315-983 posits that in the event of a sale or discontinuation of a medical
29 practice, only de-identified and/or aggregate data should be used for "business decisions,"
30 including sales, mergers, and similar business transactions when ownership or control of medical
31 records changes hands. This policy includes extensive language emphasizing the AMA's
32 commitment to protecting PHI, and that it will continue its advocacy for privacy and confidentiality
33 regulations, including: (a) The establishment of rules allocating liability for disclosure of
34 identifiable patient medical information between physicians and the health plans of which they are
35 a part, and securing appropriate physician control over the disposition of information from their
36 patients' medical records; (b) The establishment of rules to prevent disclosure of identifiable patient
37 medical information for commercial and marketing purposes; and (c) The establishment of
38 penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

39
40 In Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information," the
41 AMA commits to advocating for narrow and clearly defined bounds for the appropriate use of
42 patient information by law enforcement, payers and government entities, for operations that cannot
43 be reasonably undertaken with de-identified data. AMA Policy H-315.987, "Limiting Access to
44 Medical Records," further defines who should and should not have access to this information.

45
46 The AMA's Code of Medical Ethics includes an opinion on "Access to Medical Records by Data
47 Collection Companies." Opinion E-3.2.4 asserts that disclosing information to third parties for
48 commercial purposes without consent undermines trust, violates principles of informed consent and
49 confidentiality, and may harm the integrity of the patient-physician relationship. The opinion
50 further expresses that physicians who wish to permit third-party access to *specific patient*
51 *information* for commercial purposes should: (a) only provide data that has been de-identified, and

1 (b) fully inform each patient whose record would be involved about the purpose(s) for which
2 access would be granted. This opinion, with respect to requests for permission to allow access to or
3 disclose a *full medical record*, prohibits disclosing identifiable information for commercial
4 purposes *without obtaining consent* from the patient to do so.

5
6 The authors of Resolution 3-A-18, which established policy D-315.975 and is the subject of this
7 report, expressed particular concern that this Code of Medical Ethics Opinion may contradict itself
8 in its emphasis on informing the patient of how their de-identified data will be used and the
9 subsequent emphasis on the importance of obtaining consent. The key difference between the two
10 elements of the opinion lies in the description of the patient information being requested (specific,
11 de-identified patient information vs. full medical record), thus our AMA does not agree that these
12 statements are contradictory.

13
14 The authors also expressed that this Opinion may be in disharmony with the rules set forth in the
15 HIPAA Privacy Rule, specifically stating that authorization, rather than consent, is sometimes
16 mandated for the release of PHI when being requested for purposes not related to treatment,
17 payment, or health care operations (TPO). HIPAA defines three such uses or disclosures for which
18 written authorization of the patient is required: (1) use and disclosure of psychotherapy notes; (2)
19 use and disclosure of PHI for marketing; and (3) any sale of PHI.

20
21 Ethical Opinion E-3.2.4 was originally issued in 1994 and updated in 1998, prior to the enactment
22 of the HIPAA Privacy Rule, yet provides an even higher standard than the Rule with respect to
23 requirements for consent to disclose patient data, including data that has been de-identified. With
24 respect to authorization requirements, Opinion E-3.2.4 does not include a statement about when
25 authorization, rather than consent, is appropriate and/or required. Guidance provided in the Code of
26 Ethics is provided by standards of conduct that define the essentials of honorable behavior for the
27 physician. They cover broad ethical principles and are not intended to align with law or specific
28 regulations that may be legally enforceable. During a comprehensive eight-year modernization
29 process that ended in 2017, the AMA *Code of Medical Ethics* was reviewed for
30 relevance/timeliness of guidance, clarity, and consistency of guidance. Opinion E-3.2.4 was
31 reorganized in this process, taking the HIPAA provisions into consideration during the process.
32 Care was taken to ensure the Council on Ethical and Judicial Affairs was conservative in
33 suggesting substantive change, doing so only where needed to ensure that guidance remains
34 relevant in the face of changes in biomedical science and conditions of medical practice. No
35 contradictions or points of discord with HIPAA were identified in that review.

36 37 DISCUSSION

38 39 *Oversight of patient information*

40
41 The use of de-identified patient data is not heavily regulated. The HIPAA Privacy Rule does not
42 restrict the use or disclosure of de-identified health information, since it is not considered PHI.^{2,5}
43 HIPAA permits secondary uses of de-identified data for purposes such as public health initiatives,
44 research, law enforcement, and other public interest endeavors.^{5,15} In addition, commercial entities
45 that sell or use de-identified data, such as biotech and pharmaceutical companies, are not
46 considered covered entities under HIPAA. Through their interactions with pharmacy benefit
47 managers, pharmacies, payers, physicians and patients, however, they are indirectly impacted by
48 privacy rules and must structure their transactions, projects, and internal data programs such that
49 their partners that are covered entities or business associates thereof meet data privacy
50 requirements under HIPAA and any other applicable standards.

1 Studies that use de-identified data are exempt from regulations that govern human subject
2 research.^{2, 16} Entities that collect and use consumer data, such as pharmaceutical companies or
3 academic institutions conducting research, should employ privacy protections into their practices,
4 such as data security, reasonable collection limits, sound retention and disposal practices, and data
5 accuracy to protect privacy, as guided in recommendations from the Federal Trade Commission
6 (FTC).¹⁷ For example, Harvard University, like many academic institutions receiving federal
7 grants, implements strict policy to govern the collection, storage and use of research data, including
8 PHI.¹⁸ In addition to the enforcement of strict policy, all human subjects research is subject to
9 approval by the institution's Institutional Review Board (IRB). It is the responsibility of IRBs to
10 specify the security level for research projects they review and approve, obtain confirmation that
11 the relevant security controls are being implemented and decide if the human subject must give
12 consent or in the case of de-identified information, approve the research under an exempt status
13 from obtaining the consent.

14
15 Human subject research conducted or supported by certain federal departments or agencies is
16 governed by the Federal Policy for the Protection of Human Subjects ("Common Rule"). Revisions
17 to the Common Rule in 2017 were adopted in response to shifts in science, technology, public
18 engagement, and public expectations that have raised concerns about the limitations of the existing
19 ethical framework in research.¹⁹ The rapid pace of change in the availability, utility, and value of
20 patient data, including PHI and de-identified data, will continue to necessitate regular
21 reconsideration of the ethical oversight of patient data and how it is protected by researchers and
22 other entities.

23 24 *Risks and ethical concerns*

25
26 There are ethical concerns about the disclosure and use of de-identified health data that are rooted
27 in the risk of re-identification. Studies have shown that certain elements of patient records,
28 although not exclusive or unique to individual patients, increase the risk of re-identification if not
29 removed from individual-level data.^{20, 21} Elements such as gender, date of service, date of birth or
30 zip code can potentially be linked back to other sources of data, such as voter registration lists, and
31 could put the data at risk of re-identification.^{21, 22} Organizations that collect, store, transfer and
32 distribute de-identified data should take steps to reduce this risk, such as replacing a specific date
33 of birth or date of service with a year.

34
35 Studies have been undertaken to assess the risk of re-identification after steps have been taken to
36 de-identify the data, and have found gaps that can put de-identified patient health data at risk of
37 being re-identified.^{20, 23, 24} While these findings are significant and should not be ignored, one
38 review of some of these studies concluded that many of them were small and did not use data that
39 was de-identified according to existing standards (those set forth in the HIPAA Privacy Rule), so
40 caution should be taken when making generalizations based on the few cases identified in the
41 studies.²⁵

42
43 In addition to risk of re-identification, there are general ethical concerns with the availability and
44 use of patient health data, even if it's de-identified, without explicit authorization from patients. For
45 example, pharmaceutical companies may use de-identified data to target marketing or advertising
46 efforts to specific physicians, therefore influencing treatment plans for patient populations with
47 specific diseases or conditions. Accountable Care Organizations (ACOs), as business associates of
48 the ACO participants or a covered entity, may use de-identified data to analyze quality measures,
49 population risk scores and patient behaviors.²⁶ Other for-profit entities may use de-identified data
50 for the development of new technology or clinical innovations. These sales of patient records for
51 profit by provider organizations may raise concerns from the public that providers have an ulterior

1 motive for collecting their data during clinical encounters. In addition, patient record licensing
2 contracts with exclusive rights may raise questions about the appropriate stewardship of patient
3 data, as such exclusive contracts may be seen to benefit specific licensees at the expense of others,
4 rather than enabling research and product development across the entire marketplace.

5 *Consent and authorization*

6
7 Issues that arise in the potential risks of patient data use can be mitigated by proactively obtaining
8 appropriate authorization or consent from patients for the use of their data. These issues primarily
9 apply to PHI covered under HIPAA, however, and not de-identified data. The HIPAA Privacy Rule
10 permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and
11 disclosures of PHI for TPO. Covered entities that decide to obtain consent have complete discretion
12 to design a process that best suits their needs. By contrast, an authorization is required by the
13 Privacy Rule for most uses and disclosures of PHI not otherwise allowed by the Rule. Where the
14 Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or
15 disclosure of PHI. An authorization is a detailed document that gives covered entities permission to
16 use PHI for specified purposes (e.g., sale or marketing of PHI) or to disclose PHI to a third party
17 specified by the individual. An authorization must include a number of elements, including a
18 description of the PHI to be used and disclosed, the person authorized to make the use or
19 disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and,
20 in some cases, the purpose for which the information may be used or disclosed.²⁷

21
22 PHI may be used and disclosed for research without an authorization in limited circumstances: (1)
23 Under a waiver of the authorization requirement; (2) as a limited data set with a data use
24 agreement; (3) preparatory to research; and (4) for research on decedents' information. Limited
25 data sets exclude 16 categories of direct identifiers, rather than the 18 identifiers removed in de-
26 identified data. The information in a limited data set is considered PHI and its use or disclosure
27 requires a data use agreement between the covered entity and the entity that will receive or use the
28 data.

29
30 Non-covered entities that use de-identified health data for purposes such as genomics services or
31 research are not regulated under HIPAA, but most have policies and procedures in place to protect
32 the privacy of their subscribers or participants, and to ensure transparency in the use of the data.
33 23andMe, for example, obtains personal information from its subscribers and through its service
34 identifies genetic information that is stored within its databases. According to its Privacy Policy,
35 23andMe "implements physical, technical, and administrative measures to prevent unauthorized
36 access to or disclosure of your information, to maintain data accuracy, to ensure the appropriate use
37 of information, and otherwise safeguard your Personal Information."²⁸ Subscribers can voluntarily
38 consent to allow their information to be used in research, and can also choose what level of de-
39 identified data they consent for use. 23andMe stores and allows access to both aggregate and
40 individual level data to third-party service providers such as marketing and analytics organizations
41 and targeted advertising service providers that contribute to the service provided by 23andMe. It
42 also sells de-identified user data to pharmaceutical companies for the purposes of research.

43
44 Other entities may use anonymous, de-identified data in manners that are legal but may be
45 perceived as ethically questionable since they may not have obtained patient consent for the use of
46 the data. For example, a startup artificial intelligence business, funded by executives at a cancer
47 center, has received exclusive access to the cancer center's database of millions of tissue slides.²⁹
48 The cancer center holds an equity stake in the organization along with two of its top leaders, and
49 other board members are initial investors in the new venture. The company's leadership indicated
50 that some patients had provided consent for the use of their data, others did not and their data was

1 subsequently stripped of its identifying factors. Still, pathologists at the cancer center, and their
2 patients, have expressed concern about the potential conflict of interest in the cancer center
3 leadership's relationship with the startup, as well as the use of patient data for a profit-driven
4 venture. In this case, it was reported that the enterprise had been reviewed and approved by an
5 IRB.²⁹

6
7 *Standards and guidance*

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ONC publishes the "Guide to Privacy and Security of Electronic Health Information" to help
physicians, other health care providers and practices work to comply with federal requirements in
collecting, storing and using patients' data.³⁰

In addition to the policy set by the AMA and the guidance provided in the *AMA Code of Medical Ethics*, other physician and health care organizations provide guidelines and standards on the use of de-identified patient data. For example, the American Academy of Family Physicians published a "Data Stewardship" policy that facilitates the appropriate collection, storage, transmission, analysis, and reporting of de-identified patient data.³¹ This policy includes guidance on establishing and maintaining a proper patient and physician consent process, as well as the appropriate use of data by third parties and policies that establish requirements for third party use.

The American College of Physicians (ACP) policy encourages clinical entities and physicians to publish electronically their policies and procedures for sharing patient data and ensuring privacy. ACP's policy also states that in keeping with HIPAA, patients should know what information exists about them, its purpose, who can access and use it, and where it resides. While ACP supports the use of appropriately de-identified patient data for socially important activities, such as population health efforts and retrospective research, it does recommend tighter controls on the risks of re-identification of de-identified data.³²

CONCLUSION

Access to de-identified patient data is important for the future of health care. Its benefits to the field of research have significant implications for our ability to make progress in refining the practice of medicine, reducing health care costs, reducing and preventing chronic disease, identifying cures for deadly conditions, and much more. In practice-level interventions, de-identified data can help practice administrators recognize patterns and gaps in processes and treatment plans across clinicians. In the genomics and biotechnology fields the study of patient data, stripped of identifying factors, can contribute to global innovation in medical technology and pharmaceutical solutions. There are numerous ways in which the use of de-identified patient data contributes to the continuum of improvement that is much needed across health care.

Its use does not come without risks, however. In 1951, the development of the HeLa cell line led to many significant research accomplishments in medicine. However, the lack of patient consent in the development of the cell line raises serious ethical concerns, which were further compounded by the commercial use of the cell line for profit, which was not shared with the patient or her family. Though in recent times, substantial effort has been made to correct this historical wrong by the National Institutes of Health and other organizations, much of the harm done to patients who's clinically obtained samples were used without consent can never be undone. Today, a new revolution in health science powered by big data is in process, and there is little doubt that the research accomplishments derived from this data will transform the practice of medicine. However, all stakeholders involved now have an opportunity to ensure that there is not a repeat of the ethical mistakes of the past. Risk mitigation is the responsibility of all stakeholders, from the individual

1 clinician and patient to the administrators and third-party data users. The privacy and security of
2 the patient data must be protected at every point, and its use needs to be ethically conducted with
3 the appropriate level of consent or authorization required. The HIPAA provisions, regulations
4 enacted at the state level, and organizational policies and procedures, ensure compliance with
5 standards developed to protect the patient. If followed appropriately, these measures can effectively
6 protect patient data from misuse.

7
8 **RECOMMENDATIONS**

9
10 The Board of Trustees recommends that the following be adopted and the remainder of this report
11 be filed:

- 12
13 1. That our American Medical Association (AMA) reaffirm Policies H-315.974, “Guiding
14 Principles, Collection and Warehousing of Electronic Medical Record Information,”
15 H-315.983, “Patient Privacy and Confidentiality,” H-315.975, “Police, Payer, and Government
16 Access to Patient Health Information,” H-315.978, “Privacy and Confidentiality,” and
17 H-315.987, “Limiting Access to Medical Records.” (Reaffirm HOD Policy)
18
19 2. That our AMA support state-based efforts to protect patient privacy including the patient’s
20 right to know whether information is being disclosed or sold and to whom and the right to opt
21 out of the sale of their data. (New HOD Policy)
22
23 3. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance
24 relevant to the confidentiality of patient information in light of new practices regarding de-
25 identified patient data, including the use of exclusive de-identified data licensing agreements in
26 healthcare. (Directive to Take Action)
27
28 4. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be
29 rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: Minimal – Less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-19

Subject: Clarification to the Bylaws: Delegate Representation, Registration and Credentialing

Presented by: Jerome C. Cohen, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 It has come to the Council’s attention that several bylaw provisions relating to representation,
2 registration and credentialing of AMA delegates and alternate delegates are ambiguous. The
3 Council on Constitution and Bylaws, consistent with its functions enumerated in the Bylaws, has
4 reviewed the Bylaws and proposed changes for consideration by the House of Delegates to
5 provisions that are inconsistent and/or lack clarity.

6 7 DELEGATE REPRESENTATION

8
9 Our AMA House of Delegates, per Article IV of the AMA Constitution, is the legislative and
10 policymaking body of the Association. It is composed of elected representatives and others as
11 provided in the Bylaws. The Council believes that an underlying premise of the various AMA
12 bylaw provisions governing House of Delegates representation is that one can only represent an
13 organization of which he/she is a member. Bylaw 2.0.1.2 speaks to the multi-dimensional role of
14 delegates, including representation of the perspectives of the delegate’s sponsoring organization,
15 and Bylaw 2.10.3, “Lack of Credentials” alludes to the need for “proper identification as the
16 delegate or alternate delegate selected by the respective organization.” Nowhere, however, is
17 membership in the organization being represented explicitly stated. Bylaw 2.0.1.1, “Composition
18 and Representation,” notes only that members of the House of Delegates must be active members
19 of the AMA, but does not specify a requirement for membership in the organization being
20 represented. Alternate delegates (who are not considered members of the House of Delegates) also
21 are required to be AMA members, with nothing said about membership in the organization being
22 represented.

23
24 The Council has proposed changes to several bylaws to clarify to delegates, alternate delegates and
25 those with responsibility for certifying them, that AMA membership and membership in the
26 organization being represented is mandatory.

27 28 DELEGATION PREREGISTRATION/CREDENTIALING

29
30 A delegate registration or certification process is essential in a democratic organization to ensure
31 that only those entitled to vote may do so, and that they each vote only once. Existing AMA bylaws
32 use different terminology to identify the key individual(s) responsible for certifying the
33 organization’s delegates. Our AMA Bylaws for constituent associations and the national medical
34 specialty societies accord certification responsibility to the entity’s president or secretary, while the
35 bylaws for the AMA sections; the Surgeons General of the United States Army, United States
36 Navy, United States Air Force, and United States Public Health Service; the Chief Medical

1 Director of the Department of Veterans Affairs; the National Medical Association; the American
2 Medical Women’s Association; the American Osteopathic Association; professional interest
3 medical associations; and the AMA sections put the onus for certification on the president,
4 secretary or other authorized individual. With respect to the regional medical student delegates and
5 the delegates from the Resident and Fellow Section, the MSS or RFS chairs are responsible for
6 certifying their respective delegates and alternate delegates, although the RFS bylaws further allow
7 its chair to delegate the task, a provision that the MSS would welcome.
8

9 The Council has proposed amendments to several bylaw provisions to make the language more
10 consistent across the different groups represented in our House of Delegates. While a president is
11 recognized as the representative of any organization, certain duties/responsibilities may be
12 delegated. In practicality, it is typically the executive director or other staff person who confirms a
13 society’s credentialed representatives to the House of Delegates.
14

15 ONSITE CREDENTIALING/REGISTRATION

16
17 Our AMA Bylaws state that “certification must occur at least 30 days prior to the Annual or
18 Interim Meeting of the House of Delegates” and the Office of the House of Delegates Affairs
19 works diligently with the Federation to ensure that delegate and alternate delegate certifications are
20 received in a timely fashion. The names of the credentialed delegates and alternate delegates then
21 become part of the Official Call, which is disseminated to all House of Delegates representatives,
22 included in the House of Delegates Handbook, and serves as a starting point for a final list which is
23 then published in the meeting proceedings. Nevertheless, there are always credentialed individuals
24 who find themselves unable to attend the meeting, often at the last moment, so advance and onsite
25 substitution of representatives occurs with some frequency. Bylaw 2.10.4 addresses the use of a
26 “substitute delegate” when a delegate or alternate delegate is unable to attend a meeting, and Bylaw
27 2.10.4.1 provides for “a temporary substitute delegate” when a delegate is not able to remain in
28 attendance for the entire meeting. Last, Bylaw 2.10.3, Lack of Credentials, permits a delegate or
29 alternate delegate to be seated/credentialed onsite provided proper identification as the delegate or
30 alternate delegate selected by the respective organization is established and so certified to the
31 AMA.
32

33 The Council has heard concerns about the onsite credentialing and recredentialing processes,
34 particularly after the opening of the House of Delegates. At the 2018 Annual Meeting of the House
35 of Delegates, there were some 31 onsite delegate certifications/substitutions – 12 from constituent
36 associations, 11 from the national medical specialty societies and professional interest medical
37 associations, 4 medical student regional delegates and 4 RFS sectional delegates. Additionally,
38 there were 36 onsite delegate certifications/substitutions of alternate delegates (6 of which were
39 regional medical student delegates and 9 of which were RFS sectional delegates). At the 2018
40 Interim Meeting, there were 35 onsite delegate certifications/substitutions – 11 from constituent
41 associations, 15 from the national medical specialty societies and professional interest medical
42 associations, 7 RFS sectional delegates, and 2 regional medical student delegates. Additionally,
43 there were 23 onsite alternate delegate certifications/substitutions (of which 2 were regional
44 medical student delegates and 5 were RFS sectional delegates).
45

46 To minimize disruption and provide clarity, the Council is proposing to modify 2.10.4. and
47 subprovisions which speak to the formal recredentialing process and the timing of such. The
48 Council believes that the intent of Bylaw 2.10.4.1 as written was to allow an individual initially
49 credentialed as an alternate delegate (or substitute alternate delegate) to be recruited as a
50 delegate in a delegate’s absence. To provide a time frame, the Council has chosen “the first
51 meeting of the Committee on Rules and Credentials” (Saturday morning before the opening session

1 of the House of Delegates) as a defined point in time by which the names and credentials of all
2 delegates and alternate delegates can be finalized. At each House of Delegates meeting, each
3 delegate receives a delegate badge with an appropriate ribbon, plus an additional credential that can
4 be given to an alternate delegate should the delegate need to be out of the room at the time a vote is
5 taken. If the delegate must leave the meeting, the delegate may formally transfer his credentials to
6 either an alternate delegate or a (previously credentialed) substitute alternate delegate at the
7 registration area.

8 9 PARITY

10
11 The House of Delegates has placed great emphasis on the need for parity between the constituent
12 societies and the national medical specialty societies, and the Council, in looking at the bylaws that
13 address registration and seating of delegates, noted an inequity. Bylaw 2.10.5 states that the current
14 president of a constituent association may be certified as an additional alternate delegate at the
15 discretion of each constituent association. The Council noted that there is no corresponding bylaw
16 whereby a national medical specialty society or a professional interest medical association can
17 achieve that. To accord the same opportunity to a national medical specialty society or a
18 professional interest medical association to credential its president as an alternate delegate, the
19 Council has proposed an equivalent bylaw to ensure parity and to potentially minimize vacant
20 delegate seats for these entities.

21
22 Because of some concerns about unnecessarily swelling the size of the House, the Council looked
23 at the registration and credentialing lists from the 2018 Annual and Interim meetings. For the A-18
24 meeting, there were 13 delegate vacancies from 7 national medical specialty societies or
25 professional interest medical associations, and 101 alternate delegate vacancies from 54 societies,
26 contrasted with only 1 constituent society with a delegate vacancy and 45 alternate delegate
27 vacancies from 15 constituent societies. For the I-18 meeting, there were 23 delegate vacancies
28 from 23 national specialty societies or professional interest medical association, contrasted with 5
29 delegate vacancies from 4 constituent societies and 62 alternate delegate vacancies from 23
30 constituent societies. Thus, the Council's proposed provision to extend the same courtesy to
31 presidents of a national medical specialty society and professional interest medical association will
32 likely not result in any significant increase in credentialed alternate delegates.

33 34 RECOMMENDATIONS

35
36 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
37 Bylaws be adopted; and that the remainder of this report be filed. Adoption requires the affirmative
38 vote of two-thirds of the members of the House of Delegates present and voting.

39
40 **2.0.1 Composition and Representation.** The House of Delegates is composed of delegates
41 selected by recognized constituent associations and specialty societies, and other delegates
42 as provided in this bylaw.

43
44 **2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of
45 Delegates must be active members of the AMA and of the entity they represent.

46
47 ***

48
49 **2.1 Constituent Associations.** Each recognized constituent association granted representation
50 in the House of Delegates is entitled to delegate representation based on the number of
51 seats allocated to it by apportionment, and such additional delegate seats as may be

1 provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state,
2 commonwealth, territory, or possession shall be granted representation in the House of
3 Delegates.

4
5 ***

6
7 **2.1.4 Certification.** The president ~~or secretary~~ of each constituent association or the
8 president's designee shall certify to the AMA the delegates and alternate delegates
9 from their respective associations. Certification must occur at least 30 days prior to
10 the Annual or Interim Meeting of the House of Delegates.

11
12 ***

13
14 **2.2 National Medical Specialty Societies.** The number of delegates representing national
15 medical specialty societies shall equal the number of delegates representing the constituent
16 societies. Each national medical specialty society granted representation in the House of
17 Delegates is entitled to delegate representation based on the number of seats allocated to it
18 by apportionment, and such additional delegate seat as may be provided under Bylaw
19 2.2.2. The total number of delegates apportioned to national medical specialty societies
20 under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates
21 apportioned to constituent societies under sections 2.1.1 and 2.1.1.1.1 using methods
22 specified in AMA policy.

23
24 ***

25
26 **2.2.4 Certification.** The president ~~or secretary~~ of each specialty society or the
27 president's designee shall certify to the AMA the delegates and alternate delegates
28 from their respective societies. Certification must occur at least 30 days prior to the
29 Annual or Interim Meeting of the House of Delegates.

30
31 ***

32
33 **2.3 Medical Student Regional Delegates.** ~~In addition to the delegate and alternate delegate~~
34 ~~representing the Medical Student Section, regional M~~ medical student regional delegates
35 and alternate delegates shall be apportioned and elected as provided in this bylaw. Medical
36 student regional delegates and alternate delegates represent the constituent association that
37 endorsed their candidacy pursuant to bylaw 2.3.3.

38
39 **2.3.1 Qualifications.** Medical ~~S~~ student R regional delegates and alternate delegates must
40 be active medical student members of the AMA and attend medical school in the
41 medical student region from which they seek election. In addition, medical student
42 regional delegates and alternate delegates must be members of the constituent
43 association in the state wherein their educational program is located.

44
45 2.3.1.1 Medical student regional alternate delegates may substitute for delegates in
46 their same region in accordance with 2.8.5 and 2.10.4.

47
48 **2.3.2 Apportionment.** The total number of ~~M~~ medical S ~~student R~~ regional delegates and
49 alternate delegates is based on one delegate and one alternate delegate for each
50 2,000 active medical student members of the AMA, as recorded by the AMA on
51 December 31 of each year. Each ~~M~~ medical S ~~student R~~ region, as defined by the

1 Medical Student Section, is entitled to one delegate and one alternate delegate for
2 each 2,000 active medical student members of the AMA in an educational program
3 located within the jurisdiction of the ~~M~~medical ~~S~~student ~~R~~region....***

4
5 **2.3.3 Election.** Medical ~~S~~student ~~R~~regional delegates and alternate delegates shall be
6 elected by the Medical Student Section in accordance with procedures adopted by
7 the Section. Each elected delegate and alternate must receive written endorsement
8 from the constituent association representing the jurisdiction within which the
9 medical student's educational program is located, in accordance with procedures
10 adopted by the Medical Student Section and approved by the Board of Trustees.
11 Delegates and alternate delegates shall be elected at the Business Meeting of the
12 Medical Student Section prior to the Interim Meeting of the House of Delegates.
13 Delegates and alternate delegates shall be seated at the Annual Meeting of the
14 House of Delegates.

15
16 **2.3.4 Certification.** The Chair of the Medical Student Section Governing Council or the
17 Chair's designee shall certify to the AMA the delegates and alternate delegates ~~for~~
18 from each ~~M~~medical ~~S~~student ~~R~~region. Certification of delegates and alternate
19 delegates must occur at least 30 days prior to the Annual Meeting of the House of
20 Delegates.

21
22 **2.4 Delegates from the Resident and Fellow Section.** In addition to the delegate and alternate
23 delegate representing the Resident and Fellow Section, resident and fellow physician
24 delegates and alternate delegates shall be apportioned and elected in a manner as provided
25 in this bylaw.

26
27 **2.4.1 Qualifications.** Delegates and alternate delegates from the Resident and Fellow
28 Section must be active members of the Resident and Fellow Section of the AMA.
29 In addition, resident and fellow physician delegates and alternate delegates must be
30 members of their endorsing constituent association, national medical specialty
31 society, federal service or professional interest medical association.

32
33 **2.4.2 Apportionment.** The apportionment of delegates from the Resident and Fellow
34 Section is one delegate for each 2,000 active resident and fellow physician
35 members of the AMA, as recorded by the AMA on December 31 of each year.

36
37 **2.4.3 Election.** Delegates and alternate delegates shall be elected by the Resident and
38 Fellow Section in accordance with procedures adopted by the Section. Each
39 delegate and alternate delegate must receive written endorsement from ~~his or her~~ a
40 constituent association, or national medical specialty society, federal service or
41 professional interest medical association in accordance with procedures adopted by
42 the Resident and Fellow Section and approved by the Board of Trustees.

43
44 **2.4.4 Certification.** The Chair of the Resident and Fellow Section Governing Council ~~or~~
45 ~~his or her~~ the Chair's designee shall certify to the AMA the delegates and alternate
46 delegates for the Resident and Fellow Section. Certification of delegates and
47 alternate delegates must occur at least 30 days prior to the Annual Meeting of the
48 House of Delegates.

49
50 ***

- 1 **2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections; the
2 Surgeons General of the United States Army, United States Navy, United States Air Force,
3 and United States Public Health Service; the Chief Medical Director of the Department of
4 Veterans Affairs; the National Medical Association; the American Medical Women’s
5 Association; the American Osteopathic Association; and professional interest medical
6 associations granted representation in the House of Delegates.
7
- 8 **2.6.1 Certification.** The president, ~~secretary~~ or other authorized individual of each entity
9 shall certify to the AMA their respective delegate and alternate delegate.
10 Certification must occur 30 days prior to the Annual or Interim Meeting.
11
- 12 **2.8 Alternate Delegates.** Each organization represented in the House of Delegates may select
13 an alternate delegate for each of its delegates entitled to be seated in the House of
14 Delegates.
15
- 16 **2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of
17 the entity they represent.
18
- 19 ***
20
- 21 **2.8.5 Rights and Privileges.** An alternate delegate may substitute for a delegate, on the
22 floor of the House of Delegates, at the request of the delegate by complying with
23 the procedures established by the Committee on Rules and Credentials. While
24 briefly substituting for a delegate, the alternate delegate may speak and debate on
25 the floor of the House, offer an amendment to a pending matter, make motions,
26 and vote on all matters other than elections. If a delegate needs a substitute for
27 more than half a day, then an alternate delegate must be properly recredentialed as
28 the delegate in accordance with Bylaw 2.10.4. An alternate delegate who has been
29 properly recredentialed as the delegate in accordance with Bylaw 2.10.4 is then
30 considered a member of the House of Delegates, with all the rights and privileges
31 of a delegate.
32
- 33 **2.8.6 Status.** The alternate delegate is not a “member of the House of Delegates” as that
34 term is used in these Bylaws. Accordingly, an alternate delegate may not introduce
35 resolutions into the House of Delegates, nor vote in any election conducted by the
36 House of Delegates. An alternate delegate is not eligible for nomination or election
37 as Speaker or Vice Speaker of the House of Delegates. ~~The~~ An alternate delegate
38 must immediately relinquish his or her position on the floor of the House of
39 Delegates upon the request of the delegate for whom the alternate delegate is
40 briefly substituting.
41
- 42 ***
43
- 44 **2.10 Registration and Seating of Delegates.**
45
- 46 ***
47
- 48 **2.10.2 Credentials.** A delegate or alternate delegate representing a constituent association
49 or a national medical specialty society may only be seated if there is ~~Before being~~
50 seated at any meeting of the House of Delegates, each delegate or alternate
51 delegate shall deposit with the Committee on Rules and Credentials a certificate on

1 file submitted signed by the president, or the president's designee, secretary, or A
2 delegate or alternate delegate representing a section, federal service or professional
3 interest medical association may only be seated if there is a certificate on file
4 submitted by the section chair or other authorized individual. All certificates must
5 other authorized individual of the delegate's or alternate delegate's organization
6 stating that the delegate or alternate delegate has been properly selected to serve
7 in the House of Delegates.

8
9 **2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the
10 certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or
11 alternate delegate selected by the respective organization is established, and so
12 certified to the AMA by the organization's president, the president's designee or
13 other authorized individual.

14
15 **2.10.4 Substitute.** When a delegate or alternate delegate is unable to attend a meeting of
16 the House of Delegates, the appropriate authorities president, the president's
17 designee or other authorized individual of the organization or section may appoint
18 a substitute delegate or substitute alternate delegate prior to the first meeting of the
19 Committee on Rules and Credentials, who on presenting proper credentials shall be
20 eligible to serve as such delegate or alternate delegate in the House of Delegates at
21 that meeting.

22
23 **2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have
24 been accepted by the Committee on Rules and Credentials and whose
25 name has been placed on the roll of the House of Delegates shall
26 remain a delegate until final adjournment of that meeting of the House
27 of Delegates. However, if the delegate is not able to remain in
28 attendance, that delegate's place may be taken during the period of
29 absence by an alternate delegate, or a substitute alternate delegate
30 selected in accordance with Bylaw 2.10.4 if an alternate delegate is not
31 available. The person who takes the place of the delegate must comply
32 with the formal recredentialing procedures established by the
33 Committee on Rules and Credentials for such purpose have a
34 certification on file submitted by the president, the president's designee
35 or other authorized individual of the organization or Section, and shall
36 be known as a temporary substitute delegate. Such temporary substitute
37 delegate shall have all of the rights and privileges of a delegate while
38 serving as a temporary substitute delegate, including the right to vote in
39 the House of Delegates and to vote in any election conducted by the
40 House of Delegates. The temporary substitute delegate shall not be
41 eligible for nomination or election as Speaker or Vice Speaker of the
42 House of Delegates.

43
44 **2.10.5 Constituent Association President.** The current president of a constituent
45 association may also be certified as an additional alternate delegate at the
46 discretion of each constituent association. Certification must occur at least 30 days
47 prior to the Annual or Interim meeting of the House of Delegates.

48
49 **2.10.6 President of a National Medical Specialty Society or Professional Interest**
50 **Medical Association.** The current president of a national medical specialty society
51 or professional interest medical association may also be certified as an additional

1 alternate delegate at the discretion of each national medical specialty society and
2 professional interest medical association with representation in the House of
3 Delegates. Certification must occur at least 30 days prior to the Annual or Interim
4 meeting of the House of Delegates.

5
6 **2.10.67 Representation.** No delegate or alternate delegate may be ~~registered~~ credentialed
7 or seated at any meeting to represent more than one organization in the House of
8 Delegates.

9
10 **2.10.78 Medical Student Seating.** Each ~~M~~ medical S student ~~R~~ regional delegate shall be
11 seated with the constituent association representing the jurisdiction within which
12 such delegate's educational program is located.

13
14 **2.10.89 Resident and Fellow Seating.** Each delegate from the Resident and Fellow
15 Section shall be seated with the physician's endorsing constituent association, ~~or~~
16 specialty society, federal service or professional interest medical association. In the
17 case where a delegate has been endorsed by multiple associations ~~both a~~
18 ~~constituent association and specialty society,~~ the delegate must choose, prior to the
19 election, with which delegation the delegate wishes to be seated.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-A-19)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

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

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-19

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William C. Reha, MD, MBA, Chair)

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

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

13 14 DEFINING COMPETENCE

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

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

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

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

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

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

11 FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

12
13
14 Health care institutions and the medical profession as a whole take responsibility to regulate
15 physicians through credentialing and privileging, routinely testing knowledge (maintenance of
16 certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
17 action against physicians who fail to meet expectations for competent, professional practice.
18 However, the better part of the responsibility to maintain competence rests with physicians’
19 “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
20 to maintain a level of competence commensurate with [their] clinical roles” [11].

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

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

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

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

1 They may also question the accuracy and credibility of the assessment process and the data it
2 generates [21].
3

4 To be effective, feedback must be valued both by those being assessed and by those offering
5 assessment [14]. When there is tension between the stated goals of assessment and the implicit
6 culture of the health care organization or institution, assessment programs can too readily devolve
7 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
8 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
9 (“360° reviews”), for example, are generally better suited to providing feedback on communication
10 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
11 understand and use [14]. High quality feedback will come from multiple sources; be specific and
12 focus on key elements of the ability being assessed; address behaviors rather than personality or
13 personal characteristics; and “provide both positive comments to reinforce good behavior and
14 constructive comments with action items to address deficiencies” [22]. Beyond such formal
15 mechanisms, physicians should welcome and seek out informal input from colleagues. They should
16 be willing to offer timely comments to colleagues as well.
17

18 One study among physicians and physicians in training found that participants used a dynamic,
19 multidimensional process to assess their own abilities. Under this process of what researchers
20 identified as “informed self-assessment,” participants interpreted and responded to multiple types
21 of information, such as cognitive and affective data, from both formal and informal sources [23].
22 Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the
23 day:”
24

25 I think we do a lot of it without thinking of it as reflection. We do it every day when we look at
26 a patient’s chart. You look back and see the last visit, “What did I do, or should I have done
27 something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-
28 assessment or self-reflection, but we do it dozens of times a day [23].
29

30 EXPERTISE & EXPERT JUDGMENT

31

32 On this broad understanding of competence, physicians’ thought processes are as important as their
33 knowledge base or technical skills. Thus, understanding competence requires understanding
34 something of the nature of expertise and processes of expert reasoning, themselves topics of
35 ongoing exploration [24,25,26,27]. Prevailing theory distinguishes “fast” from “slow” thinking;
36 that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
37 analytical processes that require more conscious effort [26]. Some scholars take expertise to
38 involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
39 resources acquired through experience [24]. Others argue that expertise consists in using “slow,”
40 effortful, analytic processes to address problems [24]. A more integrative view argues that
41 expertise resides in being able to transition between intuitive and analytical processes as
42 circumstances require. On this account, experts use automatic resources to free up cognitive
43 capacity so that they maintain awareness of the environment (“situational awareness”) and can
44 determine when to shift to effortful processes [24].
45

46 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
47 automatic resources and to transition appropriately to a greater reliance on effortful processes when
48 needed” [24], a practice described as “slowing down.” Knowing when to slow down and be
49 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To
50 respond to the unexpected events that often arise in a clinical situation, the physician must
51 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to

1 transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts
2 an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
3 serves as a critical marker for intraoperative surgical judgment [24].

4 5 INFLUENCES ON CLINICAL REASONING

6
7 Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education,
8 training, and experiences that provide tools with which to shape their clinical reasoning. Every
9 physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
10 differ from the analytical and investigative processes of their colleagues in innumerable ways.
11 When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all
12 physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics
13 and habits of perception, and succumbing to overconfidence.

14 15 *Heuristics*

16
17 Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While
18 heuristics can be useful tools to help physicians identify and categorize relevant information, these
19 time-saving devices can also derail decision making. For example, a physician may mistakenly
20 assume that “something that seems similar to other things in a certain category is itself a member of
21 that category” (the representative heuristic) [28], and fail to diagnose a serious health problem.
22 Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that
23 the physician proceeds to discount as stress or intoxication once the physician learns that the
24 patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may
25 miscalculate the likelihood of a disease or injury occurring by placing too much weight “on
26 examples of things that come to mind easily, . . . because they are easily remembered or recently
27 encountered” (the availability heuristic) [28]. For example, amidst heavy media coverage of an
28 outbreak of highly infectious disease thousands of miles away in a remote part of the world, a
29 physician seeing a patient with symptoms of what is actually a more commonplace illness may
30 misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

31
32 Clinical reasoning can be derailed by other common cognitive missteps as well. These can include
33 misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to
34 remember information transferred at the beginning (or end) of an exchange but not information
35 transferred in the middle (primary or recency bias) [28,29,30].

36 37 *Habits of Perception*

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

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

6 *Overconfidence*

7
8
9 Finally, another obstacle to strong clinical reasoning that physicians may encounter is
10 overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying
11 the gaps in their knowledge [28,30]. Physicians may consider their skills to be excellent, when, in
12 fact, their peers have identified areas for improvement [30]. Overconfidence in one's abilities can
13 lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the
14 advice of others, or not acknowledging one's limits [28,30].

15
16 To avoid falling into such traps, physicians must recognize that many factors can and will influence
17 their clinical decisions [28]. They need to be aware of the information they do and do not have and
18 they need to acknowledge that many factors can and will influence their judgment. They should
19 keep in mind the likelihood of diseases and conditions and take the time to distinguish information
20 that is truly essential to sound clinical judgment from the wealth of possibly relevant information
21 available about a patient. They should consider reasons their decisions may be wrong and seek
22 alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should
23 be sensitive to the ways in which assumptions may color their reasoning and not allow expectations
24 to govern their interactions with patients.

25
26 Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming
27 aware of areas in which their skills are not at their strongest and seeking additional education or
28 consulting with colleagues, physicians can enhance their practice and best serve their patients.

29
30 Physicians' ability to practice safely can be affected by their own health, of course. The *Code of*
31 *Medical Ethics* addresses such situations in guidance on physicians' health and wellness ([E-9.3.1](#))
32 and their responsibilities to impaired colleagues ([E-9.3.2](#)).

33 34 FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

35
36 Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally
37 conceived has significant shortcomings, several scholars have argued that a different understanding
38 of self-assessment is needed, along with a different conceptualization of its role in a self-regulating
39 profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's
40 weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit
41 practice in areas in which one has limited competence, to help set appropriate learning goals, and to
42 identify areas that "should be accepted as forever outside one's scope of competent practice" [32].
43 Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence"
44 and to "set appropriately challenging learning goals" that push the boundaries of the physician's
45 knowledge [32].

46
47 If self-assessment is to fulfill these functions, physicians need to reflect on past performance to
48 evaluate not only their general abilities but also specific completed performances. At the same
49 time, they must use self-assessment predictively to assess how likely they are to be able to manage
50 new challenges and new situations. More important, physicians should understand self-assessment
51 as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in

1 the moment is critical to physicians' ethical responsibility to practice safely, at the top of their
2 expertise but not beyond it.

3
4 Expert practitioners rely on pattern recognition and other automatic resources to be able to think
5 and act intuitively. As noted above, an important component of expert judgment is transitioning
6 effectively from automatic modes of thinking to more effortful modes as the situation requires.
7 Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts
8 physicians when they need to direct additional cognitive resources to the immediate task. For
9 example, among surgeons, knowing when to "slow down" during a procedure is critical to
10 competent professional performance, whether that means actually stopping the procedure,
11 withdrawing attention from the surrounding environment to focus more intently on the task at hand,
12 or removing distractions from the operating environment [25].

13
14 Physicians should also be sensitive to the ways that interruptions and distractions, which are
15 common in health care settings, can affect competence in the moment [34,35], by disrupting
16 memory processes, particularly the "prospective memory"—i.e., "a memory performance in which
17 a person must recall an intention or plan in the future without an agent telling them to do so"—
18 important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to
19 help reduce the number or type of interruptions and distractions and mitigate their impact on
20 medical errors [37].

21
22 A key aspect of competence is demonstrating situation-specific awareness in the moment of being
23 at the boundaries of one's knowledge and responding accordingly [33]. Slowing down, looking
24 things up, consulting a colleague, or deferring from taking on a case can all be appropriate
25 responses when physicians' self-awareness tells them they are at the limits of their abilities. The
26 capacity for ongoing, attentive self-observation, for "mindful" practice, is an essential marker of
27 competence broadly understood:

28
29 Safe practice in a health professional's day-to-day performance requires an awareness of when
30 one lacks the specific knowledge or skill to make a good decision regarding a particular patient
31 This decision making in context is importantly different from being able to accurately rate
32 one's own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that
33 self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
34 self-efficacy and ongoing 'reflection-in-practice,' addressing emergent problems and
35 continuously monitoring one's ability to effectively solve the current problem [32].

36
37 Self-aware physicians discern when they are no longer comfortable handling a particular type of
38 case and know when they need to obtain more information or need additional resources to
39 supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—
40 the death of a loved one or other family crisis, or the reorganization of their practice, for example—
41 may be affecting their ability to provide care appropriately at a given time. They recognize when
42 they should ask themselves whether they should postpone care, arrange to have a colleague provide
43 care, or otherwise find ways to protect the patient's well-being.

44 45 MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

46
47 For physicians, the ideal is not simply to be "good" practitioners, but to excel throughout their
48 professional careers. This ideal holds not just over the course of a sustained clinical practice, but
49 equally when physicians re-enter practice after a hiatus, transition from active patient care to roles
50 as educators or administrators, or take on other functions in health care. Self-assessment and self-
51 awareness are central to achieving that goal.

1 A variety of strategies are available to physicians to support effective self-assessment and help
2 physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
3 day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
4 the form of written descriptions, audio or video recording, or photos of encounters with patients
5 that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
6 improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
7 standardized examinations, they are drawn from one’s actual work and require self-reflection [15].
8

9 As noted above, to be effective, self-assessment must be joined with input from others. Well-
10 designed multi-source feedback can be useful in this regard, particularly for providing information
11 about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
12 response that elicits feedback about how well one maintains trust and professional relationships
13 with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
14 tool that can have practical value in helping to correct poor behavior and, just as important,
15 consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
16 feedback will not have the rigor of a validated tool but can accomplish similar ends.
17

18 Reflective practice, that is, the habit of using critical reflection to learn from experience, is
19 essential to developing and maintaining competence across a physician’s practice lifetime [38]. It
20 enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional
21 culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
22 assessed, and that it can be developed, but also that the habit can be lost over time with increasing
23 years in practice [38].
24

25 “Mindful practice,” that is, being fully present in everyday experience and aware of one’s own
26 mental processes (including those that cloud decision making) [39], sustains the attitudes and skills
27 that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
28 behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined
29 negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can
30 be self-taught, but for most it is most effectively learned in relationship with a mentor or guide.
31 Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness.
32 Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of
33 encounters with patients, or seeking insight from critical incident reports [39].
34

35 “Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that
36 pervades all aspects of practice, including being present with the patient, solving problems,
37 eliciting and transmitting information, making evidence-based decisions, performing technical
38 skills, and defining their own values” [39].
39

40 RECOMMENDATION

41

42 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
43 remainder of this report be filed:
44

45 The expectation that physicians will provide competent care is central to medicine. It
46 undergirds professional autonomy and the privilege of self-regulation granted by society. To
47 this end, medical schools, residency and fellowship programs, specialty boards, and other
48 health care organizations regularly assess physicians’ technical knowledge and skills.
49 However, as an ethical responsibility competence encompasses more than medical knowledge
50 and skill. It requires physicians to understand that as a practical matter in the care of actual
51 patients, competence is fluid and dependent on context. Each phase of a medical career, from

1 medical school through retirement, carries its own implications for what a physician should
2 know and be able to do to practice safely and to maintain effective relationships with patients
3 and with colleagues. Physicians at all stages of their professional lives need to be able to
4 recognize when they are and when they are not able to provide appropriate care for the patient
5 in front of them or the patients in their practice as a whole.

6
7 To fulfill the ethical responsibility of competence, individual physicians and physicians in
8 training should strive to:

- 9
10 (a) Cultivate continuous self-awareness and self-observation.
11
12 (b) Recognize that different points of transition in professional life can make different
13 demands on competence.
14
15 (c) Take advantage of well-designed tools for self-assessment appropriate to their practice
16 settings and patient populations.
17
18 (d) Seek feedback from peers and others.
19
20 (e) Be attentive to environmental and other factors that may compromise their ability to
21 bring appropriate skills to the care of individual patients and act in the patient's best
22 interest.
23
24 (f) Intervene in a timely and appropriate manner when a colleague's ability to practice
25 safely is compromised by impairment, in keeping with ethics guidance on physicians'
26 responsibilities to impaired colleagues.
27

28 Medicine as a profession should continue to refine mechanisms for assessing knowledge and
29 skill and should develop meaningful opportunities for physicians and physicians in training to
30 hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than \$500.

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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-19)
Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The House of Delegates asked the Council on Ethical and Judicial Affairs (CEJA) to “study the issue of aid in dying with consideration of data collected from the states that currently authorize aid-in-dying, and input from some of the physicians who have provided medical aid-in-dying to qualified patients. CEJA was further asked to consider the need to distinguish between “physician-assisted suicide” and “aid in dying.”

In response to these requests, CEJA carried out an extensive review of relevant philosophical and empirical literature. Its deliberations have further been informed by an educational session at the 2016 Interim Meeting and consultations with stakeholders at the 2017 Annual and Interim meetings, as well as extensive correspondence from stakeholders within the medical community and the public at large. In addition, the council heard passionate testimony from both opponents and supporters of physician participation in assisted suicide at the 2018 Annual and Interim meetings.

Reflecting on this input, CEJA recognized that thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Importantly, the council found that despite deep differences, supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

CEJA interprets existing guidance in the AMA *Code of Medical Ethics* as encompassing the irreducible moral tension at stake for physicians with respect to participating in assisted suicide.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, CEJA recommends that the *Code of Medical Ethics* not be amended.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-19

Subject: Physician-Assisted Suicide
(Resolution 15-A-16 and Resolution 14-A-17)

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William C. Reha, MD, MBA, Chair)

1 At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, “Study Aid-in-
2 Dying as End-of-Life Option,” presented by the Oregon Delegation, which asked:

3
4 That our American Medical Association (AMA) and its Council on Judicial and Ethical
5 Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data
6 collected from the states that currently authorize aid-in-dying, and (2) input from some of
7 the physicians who have provided medical aid-in-dying to qualified patients, and report
8 back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA
9 taking a neutral stance on physician “aid-in-dying.”

10
11 At the following Annual Meeting in June 2017, the House of Delegates similarly referred
12 Resolution 14-A-17, “The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in
13 Dying’” (presented by M. Zuhdi Jasser, MD), which asked that our AMA:

14
15 (1) as a matter of organizational policy, when referring to what it currently defines as
16 ‘*Physician Assisted Suicide*’ avoid any replacement with the phrase ‘*Aid in Dying*’ when
17 describing what has long been understood by the AMA to specifically be ‘*Physician Assisted*
18 *Suicide*’; (2) develop definitions and a clear distinction between what is meant when the AMA
19 uses the phrase ‘*Physician Assisted Suicide*’ and the phrase ‘*Aid in Dying*’; and (3) fully utilize
20 these definitions and distinctions in organizational policy, discussions, and position statements
21 regarding both ‘*Physician Assisted Suicide*’ and ‘*Aid in Dying*.’

22
23 This report by the Council on Ethical and Judicial Affairs addresses the concerns expressed in
24 Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed
25 the philosophical and empirical literature, sought input from the House of Delegates through an I-
26 16 educational program on physician-assisted suicide, an informal “open house” at A-17, and its I-
27 17 Open Forum. The council wishes to express its sincere appreciation for participants’
28 contributions during these sessions and for additional written communications received from
29 multiple stakeholders, which have enhanced its deliberations.

30
31 The council observes that the ethical arguments advanced today supporting and opposing
32 “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined

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

1 in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again
2 as such. Rather, it considers the implications of the legalization of assisted suicide in the United
3 States since the adoption of [Opinion E-5.7](#), “Physician-Assisted Suicide,” in 1994.

4
5 “ASSISTED SUICIDE,” “AID IN DYING,” OR “DEATH WITH DIGNITY”?

6
7 Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal
8 medication to be self-administered by patients in many ways reflect the different ethical
9 perspectives that inform ongoing societal debate. Proponents of physician participation often use
10 language that casts the practice in a positive light. “Death with dignity” foregrounds patients’
11 values and goals, while “aid in dying” invokes physicians’ commitment to succor and support.
12 Such connotations are visible in the titles of relevant legislation in states that have legalized the
13 practice: “Death with Dignity” (Oregon, Washington, District of Columbia), “Patient Choice and
14 Control at the End of Life” (Vermont), “End of Life Options” (California, Colorado), “Our Care
15 Our Choice Act” (Hawaii), and in Canada’s “Medical Aid in Dying.”

16
17 Correspondingly, those who oppose physician provision of lethal medications refer to the practice
18 as “physician-assisted suicide,” with its negative connotations regarding patients’ psychological
19 state and its suggestion that physicians are complicit in something that, in other contexts, they
20 would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their
21 use obscures or sanitizes the activity. In their view such language characterizes physicians’ role in
22 a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still
23 others, meanwhile, argue that the choice by terminally ill patients to take action to end their own
24 lives with the assistance of their physician is distinct from what is traditionally understood as
25 “suicide” [4].

26
27 The council recognizes that choosing one term of art over others can carry multiple, and not always
28 intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation
29 and debate is best served by using plainly descriptive language. In the council’s view, despite its
30 negative connotations [5], the term “physician assisted suicide” describes the practice with the
31 greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The
32 terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or
33 palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing
34 ethical guidance.

35 36 COMMON GROUND

37
38 Beneath the seemingly incommensurate perspectives that feature prominently in public and
39 professional debate about writing a prescription to provide patients with the means to end life if
40 they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of
41 life. A vision that is characterized by hope for a death that preserves dignity, a sense of the
42 sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the
43 deepest aim of medicine, and fully voluntary participation on the part of both patient and physician
44 in decisions about how to approach the end of life.

45
46 Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA
47 believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and
48 well-considered perspectives about physician-assisted suicide that govern how these shared
49 commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting
50 the end of life however it comes as gracefully as one can; for another, it may mean being able to
51 exercise some measure of control over the circumstances in which death occurs. For some

1 physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to
2 abandon the patient preclude the possibility of supporting patients in hastening their death. For
3 others, not to provide a prescription for lethal medication in response to a patient’s sincere request
4 violates that same commitment and duty. Both groups of physicians base their view of ethical
5 practice on the guidance of [Principle I](#) of the AMA *Principles of Medical Ethics*: “A physician
6 shall be dedicated to providing competent medical care, with compassion and respect for human
7 dignity and rights.”

8
9 So too, how physicians understand and act on the goals of relieving suffering, respecting
10 autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and
11 values that may not be commensurate. Where one physician understands providing the means to
12 hasten death to be an abrogation of the physician’s fundamental role as healer that forecloses any
13 possibility of offering care that respects dignity, another in equally good faith understands
14 supporting a patient’s request for aid in hastening a foreseen death to be an expression of care and
15 compassion.

16 17 IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED 18 SUICIDE

19
20 How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different
21 judgments about what is an ethically permissible course of action is profoundly challenging. With
22 respect to physician-assisted suicide, some professional organizations—for example, the American
23 Academy of Hospice and Palliative Medicine [6]—have adopted a position of “studied neutrality.”
24 Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are
25 intended to respect that there are irreducible differences among the deeply held beliefs and values
26 that inform public and professional perspectives [6,7], and to leave space open for ongoing
27 discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither
28 neutral or appropriate for organized medicine [8], and as being open to unintended consequences,
29 including stifling the very debate it purports to encourage or being read as little more than
30 acquiescence with the contested practice [9].

31
32 CEJA approaches the condition of irreducible difference from a different direction. In its 2014
33 report on exercise of conscience, the Council noted that “health care professionals may hold very
34 different core beliefs and thus reach very different decisions based on those core beliefs, yet
35 equally act according to the dictates of conscience. For example, a physician who chooses to
36 provide abortions on the basis of a deeply held belief in protecting women’s autonomy makes the
37 same kind of moral claim to conscience as does a physician who refuses to provide abortion on the
38 basis of respect for the sanctity of life of the fetus” [10].

39
40 Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on
41 intuition or emotion. Rather, such decisions are based on “substantive, coherent, and reasonably
42 stable” values and principles [10]. Physicians must be able to articulate how those values and
43 principles justify the action in question.

44
45 The ethical arguments offered for more than two decades by those who support and those who
46 oppose physician participation in assisted suicide reflect the diverging “substantive, coherent, and
47 reasonably stable” values and principles within the profession and the wider moral community.
48 While supporters and opponents of physician-assisted suicide share a common commitment to
49 “compassion and respect for human dignity and rights” (AMA [Principles of Medical Ethics](#), I),
50 they draw different moral conclusions from the underlying principle they share. As psychiatrist
51 Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme

1 Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor
2 those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of
3 people contemplating end of life. Equally true: neither side is immune from impulses shaped more
4 by ideology than a deep and nuanced understanding of how to best honor and address the needs of
5 people who are suffering” [11].

6 7 THE RISK OF UNINTENDED CONSEQUENCES

8
9 From the earliest days of the debate, a prominent argument raised against permitting physician-
10 assisted suicide has been that doing so will have adverse consequences for individual patients, the
11 medical profession, and society at large. Scholars have cited the prospect that boundaries will be
12 eroded and practice will be extended beyond competent, terminally ill adult patients; to patients
13 with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to
14 encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients
15 will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting
16 the practice will compromise the integrity of the profession, undermine trust, and harm the
17 physicians and other health care professionals who participate; and that forces outside medicine
18 will unduly influence decisions.

19
20 The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide,
21 restrict the practice to terminally ill adult patients who have decision-making capacity and who
22 voluntarily request assisted suicide, along with procedural and reporting requirements—can
23 actually protect patients and sustain the integrity of medicine remains deeply contested. Some
24 studies have “found no evidence to justify the grave and important concern often expressed about
25 the potential for abuse—namely, the fear that legalized physician-assisted dying will target the
26 vulnerable or pose the greatest risk to people in vulnerable groups” [12], others question whether
27 the available data can in fact support any such conclusions, finding the evidence cited variously
28 flawed [13], inadequate [14], or distorted [15].

29
30 Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell
31 a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that
32 permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others
33 [17]. For example, research in the Netherlands has found that “requests characterized by
34 psychological as opposed to physical suffering were more likely to be rejected, as were requests by
35 individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially
36 reversible conditions might successfully end their lives.” At the same time, however, among
37 patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological
38 suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited
39 widespread concern about the emergence of a “slippery slope” [18].

40
41 Studies have also raised questions about how effective retrospective review of decisions to provide
42 euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch
43 regional euthanasia committees determined had not met legal “due care criteria” found that such
44 reviews focus on procedural considerations and do not “directly assess the actual eligibility” of the
45 patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients
46 obtained euthanasia found that physicians’ reports “stated that psychosis or depression did or did
47 not affect capacity but provided little explanation regarding their judgments” and that review
48 committees “generally accepted the judgment of the physician performing EAS [euthanasia or
49 physician-assisted suicide]” [20]. It remains an open question whether reviews that are not able to
50 assess physicians’ reasoning truly offer the protection they are intended to provide. To the extent

1 that reporting and data collection in states that permit physician-assisted suicide have similar
2 limitations, oversight of practice may not be adequate.

3
4 Medicine must learn from this experience. Where physician-assisted suicide is legalized,
5 safeguards can and should be improved—e.g., “[t]o increase safeguards, states could consider
6 introducing multidisciplinary panels to support patients through the entire process, including
7 verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all
8 palliative and end-of-life options” [21]. Both the state and the medical profession have a
9 responsibility to monitor ongoing practice in a meaningful way and to address promptly
10 compromises in safeguards should any be discovered. It is equally important that strong practices
11 be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health
12 care organizations in California and Canada, for example, have shared richly descriptive reports of
13 practices adopted in response to the recent legalization of “aid in dying” in those jurisdictions that
14 seek to address concerns about quality of practice and data collection [22,23].

15
16 Medicine must also acknowledge, however, that evidence (no matter how robust) that there have
17 not yet been adverse consequences cannot guarantee that such consequences would not occur in the
18 future. As a recent commentary noted, “[p]art of the problem with the slippery slope is you never
19 know when you are on it” [17].

20 21 SAFEGUARDING DECISIONS AT THE END OF LIFE

22
23 CEJA has found that just as there are shared commitments behind deep differences regarding
24 physician-assisted suicide, there are also shared concerns about how to understand the available
25 evidence. For example, in the council’s recent Open Forum, both proponents and opponents of
26 physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health
27 care system in which patients have uneven access to care, including access to high quality end-of-
28 life care. They also noted that patients and physicians too often still do not have the conversations
29 they should about death and dying, and that too few patients are aware of the range of options for
30 end-of-life care, raising concern that many patients may be led to request assisted suicide because
31 they don’t understand the degree of relief of suffering state-of-the-art palliative care can offer.
32 Participants who in other respects held very different views concurred as well that patients may be
33 vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed
34 concern in common that forces external to medicine could adversely influence practice.

35
36 These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in*
37 *America* [24]. They are concerns echoed in a February 2018 workshop on physician-assisted death
38 convened by the National Academies of Science, Engineering and Medicine [25]. They underscore
39 how important it is to understand *why* a patient requests assisted suicide as a starting point for care
40 [26].

41
42 Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that
43 are too often avoided. They open opportunities to explore the patient’s goals and concerns, to learn
44 what about the situation the individual finds intolerable and to respond creatively to the patient’s
45 needs other than providing the means to end life—by such means as better managing symptoms,
46 arranging for psychosocial or spiritual support, treating depression, and helping the patient to
47 understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must
48 ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable
49 about the options available to terminally ill patients [28]. The profession also has a responsibility to
50 advocate for adequate resources for end-of-life care [16,28], particularly for patients from

1 disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to
2 interfere with excellent care at the end of life.

3
4 CONCLUSION

5
6 At the core of public and professional debate, the council believes, is the aspiration that every
7 patient come to the end of life as free as possible from suffering that does not serve the patient's
8 deepest self-defining beliefs and in the presence of trusted companions, including where feasible
9 and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more
10 than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey,
11 or of separating their person from their disease" [27]. Decisions about how to approach the end of
12 life are among the most intimate that patients, families, and their physicians make. Respecting the
13 intimacy and the authenticity of those relationships is essential if our common ideal is to be
14 achieved.

15
16 While supporters and opponents of physician-assisted suicide share a common commitment to
17 "compassion and respect for human dignity and rights" ([AMA Principles of Medical Ethics](#), I),
18 they draw different moral conclusions from the underlying principle they share. Where one
19 physician understands providing the means to hasten death to be an abrogation of the physician's
20 fundamental role as healer that forecloses any possibility of offering care that respects dignity,
21 another in equally good faith understands supporting a patient's request for aid in hastening a
22 foreseen death to be an expression of care and compassion.

23
24 RECOMMENDATION

25
26 The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful
27 input from numerous individuals and organizations to inform its deliberations, and is deeply
28 grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion
29 about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the irreducible
30 differences in moral perspectives identified above. The council recognized that supporters and
31 opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but
32 diverge in drawing different moral conclusions from those underlying values in equally good faith.
33 The council further recognized that medicine must learn from experience of physician-assisted
34 suicide, and must ensure that, where the practice is legal, safeguards are improved.

35
36 After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide
37 and the exercise of conscience, the *Code* offers guidance to support physicians and the patients
38 they serve in making well-considered, mutually respectful decisions about legally available options
39 for care at the end of life in the intimacy of a patient-physician relationship.

40
41 Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-
42 assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support
43 assisted suicide, the Council on Ethical and Judicial Affairs recommends that the *Code of Medical*
44 *Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted, and that the
45 remainder of the report be filed.¹

Fiscal Note: None.

¹ CEJA plans to present E-5.7 and E-1.1.7 in online and print versions of the *Code of Medical Ethics* as suggested in the Appendix.

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APPENDIX

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

- (a) Should not abandon a patient once it is determined that cure is impossible.
- (b) Must respect patient autonomy.
- (c) Must provide good communication and emotional support.
- (d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and

committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-19

Subject: CEJA's Sunset Review of 2009 House Policies

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William C. Reha, MD, MBA, Chair)

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

4
5 The objective of the sunset mechanism is to help ensure that the American Medical Association
6 (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative,
7 and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to
8 communicate and promote its policy positions. It also contributes to the efficiency and
9 effectiveness of HOD deliberations.

10
11 At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through
12 which the policy sunset review is conducted. The process now includes the following steps:

- 13
- 14 • Each year the House policies that are subject to review under the policy sunset mechanism
- 15 are identified.
- 16 • Policies are assigned to appropriate Councils for review.
- 17 • For the Annual Meeting of the House, each Council develops a separate policy sunset
- 18 report that recommends how each policy assigned to it should be handled. For each policy
- 19 it reviews, a Council may recommend one of the following actions: (a) retain the policy;
- 20 (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent
- 21 and like policy. A justification must be provided for the recommended action to retain a
- 22 policy.
- 23 • A policy will typically sunset after ten years unless action is taken by the House of
- 24 Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates
- 25 resets the sunset clock, making the reaffirmed or amended policy viable for another 10
- 26 years.
- 27

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

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

1 2009 POLICIES

2

3 In this report, the Council on Ethical and Judicial Affairs (CEJA) presents its recommendations
4 regarding the disposition of 2009 House policies that were assigned to or originated from CEJA.

5

6 DUPLICATIVE POLICIES

7

8 On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint
9 Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report
10 recommends the rescission of House policies issued since June 2009. As noted previously, the
11 intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The
12 process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a
13 category of AMA policy.

14

15 MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

16

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

20

21 For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report
22 8-I-07, "Pediatric Decision-Making." It was recorded in PolicyFinder as Policy H-140.865. At the
23 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a
24 duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA
25 recommended the rescission of Policy H-140.865 as part of the Council's 2009 sunset report.

26

27 The Appendix provides recommended actions and their rationale on House policies from 2009, as
28 well as on duplicate policies.

29

30 RECOMMENDATION

31

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

Fiscal Note: Less than \$500.

APPENDIX - RECOMMENDED ACTIONS

Policy No.	Title	Recommended Action & Rationale
D-105.998	Direct to Consumer Advertising D-105.998	Rescind The goal of this directive was accomplished through AMA communication to the Food and Drug Administration. Policy H-105.988 , Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices to which it refers remains in effect.
D-250.991	Victims of the War in Kosovo	Rescind. Policy is outdated. The goal of this directive was originally accomplished by the establishment of the Physician Opportunities Portal, which has been discontinued.
D-250.992	Medical Supply Donations to Foreign Countries	Rescind. Policy is outdated and duplicates efforts of the World Health Organization, which provides up-to-date international information and guidelines on humanitarian donations of medical supplies at https://www.who.int/hac/crises/ht/i/appeal/medical_supplies/en/ .
D-315.994	Abuse of the Medical Record for Regulation or Financing the Practice of Medicine	Rescind The goal of this directive is accomplished through extensive materials available at https://www.ama-assn.org/search?search=confidentiality%2C+medical+records&sort_by=search_api_relevance
D-315.996	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	Rescind The goal of this directive is accomplished by extensive materials available at https://policysearch.ama-assn.org/policyfinder/search/HIPAA/relevant/1/
D-373.998	Guidelines for Handling Derogatory Conduct in the Patient-Physician Relationship	Rescind The goal of this directive was accomplished in AMA correspondence to the Joint

		Commission and directive is duplicative of E-1.2.2 , Disruptive Behavior by Patients. This issue is currently under further consideration by the Council on Ethical and Judicial Affairs in response to Resolution 18-A-18.
D-460.974	Office for Human Research Protections Interpretation of 45 CFR Part 46	Rescind The goal of this directive was accomplished in AMA correspondence with the Office of Human Research Protections and has been superseded by the revised Common Rule (2017).
D-460.991	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	Rescind This directive is outdated and is superseded by the revised Common Rule (2017).
D-60.970	Disclosure of Health Status to Children and Adolescents	Rescind The goal of this directive was accomplished by amendments to E-2.1.1 , Pediatric Decision Making, adopted in 2010, 2018.
D-70.954	Transition to ICD-10 Code Sets	Rescind The goal of this directive is accomplished by extensive material available at https://www.ama-assn.org/search?search=ICD-10
H-5.990	Policy on Abortion	Reaffirm
H-65.985	Inappropriate Federal Prosecution	Reaffirm
H-140.921	Preserving the Traditional Patient-Physician Relationship	Rescind Policy is outdated and duplicative of guidance in the modernized <i>Code of Medical Ethics</i> (2016): E-8.6 , Promoting Patient Safety E-9.5.2 , Staff Privileges E-10.1 , Ethics Guidance for Physicians in Nonclinical Roles E-11.2.1 Professionalism in Health Care Systems E-11.2.2 , Conflicts of Interest in Patient Care E-11.2.3 , Contracts to Deliver Health Care Services E-11.2.4 , Transparency in Health Care
H-140.926	Policy for Physician Entrepreneur Activity	Reaffirm
H-140.949	Physician-Assisted Suicide	Rescind

		<p>Title is misleading in that this policy, originally adopted in 1996, focuses on palliative care, not physician-assisted suicide. AMA has subsequently developed extensive policy in this area:</p> <p>H-70.915, Good Palliative Care (2014) H-295.875, Palliative Care and End of Life Care (2006) H-85.951, Concurrent Hospice and Curative Care (2016) H-85.955, Hospice Care (2014) D-600.984 Specialty Organizations Seated in our AMA House of Delegates (2018), seating the American Academy of Hospice and Palliative Medicine E-5.1, Advance Care Planning (2010)</p>
H-140.952	Physician Assisted Suicide	Reaffirm
H-140.951 H-140.996	<p>Professionalism and Medical Ethics Reaffirmation of Professionalism</p> <p>Professionalism and Medical Ethics H-140.951 The AMA reaffirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state cannot legislate ethical standards or excuse physicians from their ethical obligations; and urges all physicians and other appropriate health professional organizations to make their views known to their state legislatures and governors.</p> <p>Reaffirmation of Professionalism H-140.996 Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.</p>	<p>Consolidate and retitle: H-140.951 Professionalism in Medicine Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.</p>
H-190.958	Readability of Medical Notices of Privacy Practices	<p>Rescind AMA provides sample language for notice of privacy practices at</p>

		https://www.ama-assn.org/practice-management/hipaa/hipaa-privacy-security-resources
H-315.997	Patients' Access to Information Contained in Medical Records	Rescind Policy is outdated. HIPAA mandates patient access to their medical records.
H-315.998	Medical Record Privacy	Rescind. Policy adopted in 1979 is superseded by more recent law and regulation. AMA model legislation on this issue is no longer publicly available.
H-350.971 H-350.975	Initiatives Regarding Minorities Improving Healthcare of Hispanic Populations in the United States	Defer recommendation to 2019 Interim meeting pending review by Chief Health Equity Officer. Consider consolidating these and other policies that address identified patient populations and health disparities: H-160.991 Health Care Needs of Gay, Lesbian, Bisexual and Transgender Populations H-295.878 Eliminating Health Disparities—Promoting Awareness and Education of Lesbian, Gay, Bisexual and Transgender (LGBT) Issues in Medical Education H-350.957 Addressing Immigrant Health Disparities H-350.958 Hispanic Population and Access to the US Healthcare System H-350.959 Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities H-350.961 Improving the Health of Minority Populations H-350.966 Health Initiatives on Asian-Americans and Pacific Islanders

		<p>H-350.971 AMA Initiatives Regarding Minorities</p> <p>H-350.972 Improving the Health of Black and Minority Populations</p> <p>H-350.974 Racial and Ethnic Disparities in Health Care</p> <p>H-350.976 Improving Health Care of American Indians</p> <p>H-440.869 Establishment of State Commission/Task Force to Eliminate Racial and Ethnic Health Care Disparities</p> <p>D-350.996 Strategies for Eliminating Minority Health Care disparities</p> <p>D-55.997 Cancer and Health Care Disparities among Minority Women</p> <p>D-65.995 Health Care Disparities among Gay, Lesbian, Bisexual and Transgender Families</p>
H-405.982	Medical Informatics - Policy Initiatives for the AMA	Rescind Superseded by AMA digital health resources at https://www.ama-assn.org/search?search=digital+health
H-515.967	Protection of the Privacy of Sexual Assault Victims	Reaffirm

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-19)

Introduced by: Illinois

Subject: Opposing Attorney Presence at and/or Recording of Independent Medical Examinations

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, An independent medical examination or IME (also known as a compulsory medical
2 examination or CME) is an integral component used in civil litigation to resolve questions about
3 a particular medical condition or care; and
4

5 Whereas, Recording, videotaping, or allowing the presence of a court reporter or opposing
6 attorney during the IME can, simply by their presence, obstruct efforts to properly obtain medical
7 information and can create an adversarial environment; and
8

9 Whereas, Courts are increasingly compelling physicians to agree to the above conditions as a
10 condition to testifying; and
11

12 Whereas, No other professionals are compelled to agree to these conditions as a condition to
13 testifying; and
14

15 Whereas, Any significant collateral medical issue discovered during the IME must be disclosed
16 to the patient, and thus a partial patient-physician relationship actually does exist; and
17

18 Whereas, The recording of the IME is the property of the legal representative of the person
19 being examined and can be used in future trials or venues as they see fit; therefore be it
20

21 RESOLVED, That our American Medical Association amend Policy H-365.981, "Workers'
22 Compensation," by addition to read as follows:
23

24 Our AMA:

25 (1) will promote the development of practice parameters, when appropriate, for use in
26 the treatment of injured workers and encourages those experienced in the care of
27 injured workers to participate in such development.

28 (2) will investigate support for appropriate utilization review guidelines for referrals,
29 appropriate procedures and tests, and ancillary services as a method of containing
30 costs and curbing overutilization and fraud in the workers' compensation system. Any
31 such utilization review should be based on open and consistent review criteria that are
32 acceptable to and have been developed in concert with the medical profession.

33 Physicians with background appropriate to the care under review should have the
34 ultimate responsibility for determining quality and necessity of care.

35 (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The
36 correct use of the Guides can facilitate prompt dispute resolution by providing a single,
37 scientifically developed, uniform, and objective means of evaluating medical
38 impairment.

1 (4) encourages physicians to participate in the development of workplace health and
2 safety programs. Physician input into healthy lifestyle programs (the risks associated
3 with alcohol and drug use, nutrition information, the benefits of exercise, for example)
4 could be particularly helpful and appropriate.

5 (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing
6 (with appropriate mechanisms to protect the confidentiality of patient information), and
7 familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when
8 appropriate, to facilitate prompt reporting and payment of workers' compensation
9 claims.

10 (6) will evaluate the concept of Independent Medical Examinations (IME) and make
11 recommendations concerning IME's (i) effectiveness; (ii) process for identifying and
12 credentialing independent medical examiners; and (iii) requirements for continuing
13 medical education for examiners.

14 (7) encourages state medical societies to support strong legislative efforts to prevent
15 fraud in workers' compensation.

16 (8) will continue to monitor and evaluate state and federal health system reform
17 proposals which propose some form of 24-hour coverage.

18 (9) will continue to evaluate these and other medical care aspects of workers'
19 compensation and make timely recommendations as appropriate.

20 (10) will continue activities to develop a unified body of policy addressing the medical
21 care issues associated with workers' compensation, disseminate information
22 developed to date to the Federation and provide updates to the Federation as
23 additional relevant information on workers' compensation becomes available.

24 (11) opposes the ability of courts to compel recording and videotaping of, or allow a
25 court reporter or an opposing attorney to be present during, the independent medical
26 examination, as a condition for the physician's medical opinions to be allowed in court.

27 (Modify Current HOD Policy); and be it further
28

29 RESOLVED, That revised AMA Policy H-365.981, "Workers Compensation," be included in the
30 AMA's *Guide to the Evaluation of Permanent Impairment*. (New HOD Policy)

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

Received: 03/20/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-19)

Introduced by: Minnesota

Subject: Addressing Existential Suffering in End-of-Life Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, The duty to relieve pain and suffering is central to the physician's role as healer; and
2
3 Whereas, Patients may experience both physical and existential suffering at the end-of-life; and
4
5 Whereas, Sedation to unconsciousness is an ethical practice to address refractory clinical
6 symptoms, but is inappropriate to respond to existential suffering; and
7
8 Whereas, Existential suffering includes anxiety, isolation, loss of control, and other non-physical
9 suffering that are serious conditions impacting patients' health; and
10
11 Whereas, Pharmacological or other clinical options short of sedation to unconsciousness may
12 be appropriate to mitigate a patient's existential suffering; and
13
14 Whereas, Physicians have an ethical obligation to respect and consider the previously
15 expressed wishes of a patient who has lost the ability to provide consent; and
16
17 Whereas, Existing AMA Council on Ethical and Judicial Affairs Opinion 5.6 addresses many of
18 these issues in detail but does not expressly address two areas; and
19
20 Whereas, CEJA Opinion 5.6 states that existential suffering should be addressed through
21 social, psychological, or spiritual support to the exclusion of other clinical options, even though
22 there are treatments for existential suffering beyond social, psychological or spiritual support
23 that are beneficial for patients; and
24
25 Whereas, CEJA Opinion 5.6 states that consent must be obtained from the patient or surrogate,
26 but does not recognize or require consideration of a patient's previously expressed wishes in
27 the case of surrogate decision making; therefore be it
28
29 RESOLVED, That our American Medical Association ask the Council on Judicial and Ethical
30 affairs to review Ethical Opinion 5.6, "Sedation to Unconsciousness in End-of-Life Care," to
31 address the following two issues: appropriate treatments beyond social, psychological or
32 spiritual support to treat existential suffering, and the recognition of a patient's previously
33 expressed wishes with end-of-life care. (Directive to Take Action)

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

Received: 04/24/19

References:

1. N Kirk, T. W., & Mahon, M. M. (2010). National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients. *Journal of pain and symptom management*, 39(5), 914-923.
2. American Academy of Hospice and Palliative Medicine Statement on Palliative Sedation, <http://aahpm.org/positions/palliative-sedation>.

RELEVANT AMA POLICY

E-5.6 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physicians role as healer and is an obligation physicians have to their patients. When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation it can be appropriate to offer sedation to unconsciousness as an intervention of last resort.

Sedation to unconsciousness must never be used to intentionally cause a patients death.

When considering whether to offer palliative sedation to unconsciousness, physicians should:

- (a) Restrict palliative sedation to unconsciousness to patients in the final stages of terminal illness.
- (b) Consult with a multi-disciplinary team (if available), including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.
- (c) Document the rationale for all symptom management interventions in the medical record.
- (d) Obtain the informed consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).
- (e) Discuss with the patient (or surrogate) the plan of care relative to:
 - (i) degree and length of sedation;
 - (ii) specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.
- (f) Monitor care once palliative sedation to unconsciousness is initiated.

Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-19)

Introduced by: GLMA: Health Professionals Advancing LGBTQ Equality
Subject: Conforming Sex and Gender Designation on Government IDs and Other Documents
Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, The current US population of transgender adults is estimated to be about 0.6% of the
2 US population, or about 1.4 million adults¹; and
3
4 Whereas, A 2015 U.S. Transgender Survey conducted by the National Center for Transgender
5 Equality (NCTE) found that 68% of transgender individuals live without a valid ID that matches
6 their gender identity²; and
7
8 Whereas, The same survey noted that nearly one third (32%) of those who showed ID that did
9 not match their gender presentation were verbally harassed, denied benefits or service, asked
10 to leave, or assaulted²; and
11
12 Whereas, The cost of updating gender markers and procedural requirements (such as providing
13 documentation of medical information) are among the main barriers preventing respondents
14 from updating the gender on their IDs and records²; and
15
16 Whereas, One in four (25%) respondents reported problems regarding medical insurance in the
17 past year related to being transgender, such as being denied coverage for care related to
18 gender transition²; and
19
20 Whereas, Seventeen percent (17%) of respondents had an insurer refuse to change the name
21 and/or gender in insurance records when requested and thirteen percent (13%) reported denial
22 of coverage for services often considered to be gender-specific, including routine sexual or
23 reproductive health screenings (such as Pap smears, prostate exams, and mammograms)²; and
24
25 Whereas, Government issued IDs include, but are not limited to, birth certificates, passports,
26 driver's licenses, state identification cards, and other local, state, and federally issued
27 identification; and
28
29 Whereas, At least ten states plus New York City and the District of Columbia currently issue
30 updated sex designations on birth certificates and/or driver's licenses without requiring
31 documentation from a medical provider: Arkansas,³ California,⁴ District of Columbia,⁵ Idaho,⁶
32 Massachusetts,⁷ Minnesota,⁸ Montana,⁹ Nevada,¹⁰ New Jersey,¹¹ New York City,¹² Oregon,¹³
33 and Washington¹⁴; and
34
35 Whereas, At least ten states plus New York City and the District of Columbia offer birth
36 certificates and/or driver's licenses with a gender-neutral option: California,⁴ Colorado,¹⁵
37 Connecticut,¹⁶ District of Columbia,⁵ Maine,¹⁷ Minnesota,¹⁸ Nevada,¹⁰ New Jersey,¹¹ New York
38 City,¹² Oregon,¹⁹ Arkansas,³ and Washington¹⁴; and

1 Whereas, Our AMA has strong policy advocating for removal of barriers to change the sex
 2 designation of an individual's birth certificate (H-65.967), but has outdated requirements for the
 3 change of sex designation and does not include mention of other government IDs within this
 4 policy; therefore be it

5
 6 RESOLVED, That our American Medical Association modify HOD Policy H-65.967, "Conforming
 7 Birth Certificate Policies to Current Medical Standards for Transgender Patients," by addition
 8 and deletion to read as follows:

9
 10 ~~Conforming Birth Certificate Policies to Current Medical Standards for Transgender~~
 11 ~~Patients Sex and Gender Designation on Government IDs and Other Documents (H-~~
 12 ~~65.967)~~

13
 14 ~~1. Our AMA supports policies that allow for a change of sex designation on birth~~
 15 ~~certificates for transgender individuals based upon verification by a physician (MD or DO)~~
 16 ~~that the individual has undergone gender transition according to applicable medical~~
 17 ~~standards of care every individual's right to determine their gender identity and sex~~
 18 ~~designation on government documents and other forms of government identification.~~

19
 20 ~~2. Our AMA supports policies that allow for a sex designation or change of designation on~~
 21 ~~all government IDs to reflect an individual's gender identity, as reported by the individual~~
 22 ~~and without need for verification by a medical professional.~~

23
 24 ~~3. Our AMA supports policies that include an undesignated or nonbinary gender option~~
 25 ~~for government records and forms of government-issued identification, which would be in~~
 26 ~~addition to "male" and "female."~~

27
 28 ~~4. Our AMA: (a) supports elimination of any requirement that individuals undergo gender~~
 29 ~~affirmation surgery in order to change their sex designation on birth certificates and~~
 30 ~~supports modernizing state vital statistics statutes to ensure accurate gender markers on~~
 31 ~~birth certificates; and (b) supports that any change of sex designation on an individual's~~
 32 ~~birth certificate not hinder access to medically appropriate preventive care supports~~
 33 ~~efforts to ensure that the sex designation on an individual's government-issued~~
 34 ~~documents and identification does not hinder access to medically appropriate care or~~
 35 ~~other social services in accordance with that individual's needs. (Modify Existing Policy)~~

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

Received: 05/01/19

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4. California Gender Recognition Act, SB 179, https://leginfo.ca.gov/faces/billCompareClient.xhtml?bill_id=201720180SB179.
5. DC Gender Self-Designation Form, <https://dmv.dc.gov/sites/default/files/dc/sites/dmv/publication/attachments/DC%20DMV%20Form%20Gender%20Self-Designation%20English.pdf>.
6. Idaho Division of Public Health Instructions to Change the Indicator of Sex on an Idaho Birth Certificate to Reflect Gender Identity, https://healthandwelfare.idaho.gov/Portals/0/Health/Vital%20Records/GenderChangePacket_4-18.pdf.

7. MA Gender Designation Change Form, https://www.mass.gov/files/documents/2018/03/22/LIC108%20-%20Massachusetts%20Gender%20Designation%20Change%20Form_0.pdf.
8. Minnesota Driver and Vehicle Services Self-Designated Descriptors, <https://dps.mn.gov/divisions/dvs/Pages/self-designated-descriptors.aspx>
9. Montana Rule 37.8.311, Adoptions, Name Changes, and Gender Changes, <http://www.mtrules.org/gateway/RuleNo.asp?RN=37.8.311>
10. Nevada Administrative Code 440.030, [https://www.leg.state.nv.us/Register/RegsReviewed/\\$R066-16A.pdf](https://www.leg.state.nv.us/Register/RegsReviewed/$R066-16A.pdf). Nevada Administrative Code 483-070, and see <http://dmv.nv.com/namechange.htm>.
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12. New York City Health Code Article 207, <https://www1.nyc.gov/assets/doh/downloads/pdf/notice/2018/noa-amend-article207-section207-05.pdf>.
13. Oregon Health Authority House Bill 2673 Information Sheet, <https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/CHANGEVITALRECORDS/Documents/OHA-2673.pdf>; Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.
14. Washington WAC 246-490-075, Changing sex designation on a birth certificate, <http://app.leg.wa.gov/WAC/default.aspx?cite=246-490-075>.
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17. Maine Gender Designation Form, <https://www1.maine.gov/sos/bmv/forms/GENDER%20DESIGNATION%20FORM.pdf>.
18. MN Driver and Vehicle Services Self-Designated Descriptors, <https://dps.mn.gov/divisions/dvs/Pages/self-designated-descriptors.aspx>
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RELEVANT AMA POLICY

Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work 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; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth. Citation: Res. 003, A-17; Modified: Res. 005, I-18

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.

Citation: (Res. 4, A-13; Appended: BOT Rep. 26, A-14

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates.

Citation: (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: (Res. 402, A-12

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer 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, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ 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 LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ 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 sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy 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; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ 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 LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) 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; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Nondiscriminatory Policy for the Health Care Needs of LGBTQ 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.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will 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 ones gender identity.

Citation: Res. 010, A-17

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoners genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-19)

Introduced by: New York

Subject: Reimbursement for Care of Practice Partner Relatives

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Medicare has rules that exclude Medicare payments for items and services that,
2 Medicare deems, would be furnished gratuitously because of the relationship of the beneficiary
3 to the person imposing the charge; and
4
5 Whereas, Chapter 16 of Medicare guidelines (130 - Charges Imposed by Immediate Relatives
6 of the Patient or Members of the Patient's Household (Rev. 1, 10-01-03) A3-3161, HO-260.12,
7 B3-2332) defines rules, these guidelines have not been revised since 2014; and
8
9 Whereas, The following degrees of relationship are included in definition of an immediate
10 relative including husband and wife, natural or adoptive parents, child and sibling, stepparent,
11 stepchild, stepbrother, stepsister, in-laws, grandparents, grandchildren and spouses of such
12 grandparents and grandchildren; and
13
14 Whereas, Exclusion applies whether the provider is a sole proprietor who has an excluded
15 relationship to the patient or a partnership in which even one of the partners is related to the
16 patient; and
17
18 Whereas, Medicare makes the false assumption that a cardiologist seeing the father-in-law of
19 an internist in his group would be compelled to provide cardiology services for free. This places
20 the physician providing services in a difficult position where they provide services at a loss or
21 must refuse to see the patient. This also puts the physicians, whose family member requires
22 care, in an awkward predicament. They must either ask colleague to see their family member at
23 a loss or tell the family member that it is not possible to be seen in their practice. Thus, this
24 regulation strains physician-patient relationships and restricts access to trusted care; therefore
25 be it
26
27 RESOLVED, That our American Medical Association support changes in the Medicare
28 guidelines to allow a physician, who is a partner in the practice, to care for and receive
29 appropriate reimbursement for immediate relatives of one of the other partners in their practice.
30 (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-19)

Introduced by: New York

Subject: Right for Gamete Preservation Therapies

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, A small but significant number of individuals have gender identities that differ from
2 their genotypic and phenotypic gender; and
3
4 Whereas, An increasing number of these individuals will choose to undergo gender affirming
5 treatment at some time during their reproductive lives; and
6
7 Whereas, Many transgender or non-binary individuals may desire to have children of their own
8 just as cisgender individuals desire to have children of their own; and
9
10 Whereas, In order for a transgender or non-binary individual to have their own biological child,
11 he or she generally must preserve their gametes prior to undergoing gender affirming medical
12 and surgical therapies; therefore be it
13
14 RESOLVED, That fertility preservation services be officially recognized by our American
15 Medical Association as an option for the members of the transgender and non-binary
16 community who wish to preserve future fertility through gamete preservation prior to undergoing
17 gender affirming medical or surgical therapies (New HOD Policy); and be it further
18
19 RESOLVED, That our AMA officially support the right of transgender or non-binary individuals to
20 seek gamete preservation therapies. (New HOD Policy)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-19)

Introduced by: Wisconsin

Subject: Use of Person-Centered Language

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, Communication is one of the foundational aspects of patient care that impacts patient
2 satisfaction and builds rapport between a physician and patient;¹ and
3
4 Whereas, Person-first language is a style of communication in which the person is listed first
5 followed by descriptive terms, such as a disease state (e.g. “a person with schizophrenia” rather
6 than “a schizophrenic”), which avoids defining a person by his or her disease state and places
7 the emphasis on the person rather than the disease or disability; and
8
9 Whereas, The use of person-first language may improve the doctor-patient relationship,²
10 encourage a healthy relationship between researchers and the community,^{3,4} and may reduce
11 stigma associated with certain disease states;^{5,6} and
12
13 Whereas, Multiple organizations including the federal Center for Disease Control and
14 Prevention, American Psychological Association, and American Society of Addiction Medicine
15 encourage person-first language;^{7,8,9,10,11,12} and
16
17 Whereas, Person-centered language is a style of communication that incorporates an
18 individual’s preference and identity when referring to a disease state (e.g. “a blind person” or “a
19 person with blindness” based on personal preference), which may deviate from person-first
20 language; and
21
22 Whereas, The use of person-centered language focuses on each person’s individual
23 preferences rather than using generalizing terms for a group when referring to a disease state
24 or disability, which seeks to maintain dignity and respect for all individuals;^{13,14} and
25
26 Whereas, Certain groups - such as the deaf and the blind communities - speak against using
27 person-first language because they identify their disability as a trait they possess instead of a
28 pathologic process, and this issue is mitigated by using person-centered language;^{15,16} and
29
30 Whereas, The Canadian Alzheimer's Society has developed specific guidelines for using
31 person-centered language as to “not diminish the uniqueness and intrinsic value of each person
32 and to allow a full range of thoughts, feeling and experiences to be communicated,” and to
33 continue to build trusting relationships with these patients regardless of their condition;¹³ and
34
35 Whereas, The AMA recommends the use of person-first language in the AMA Code of Style,
36 and recently adopted policy regarding the use of person-first language for obesity (H-440.821)
37 but failed to include other disease states; therefore be it

- 1 RESOLVED, That our American Medical Association encourage the use of person-centered
2 language. (New HOD Policy)

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

Received: 05/01/19

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AMA Manual of Style > Section 2 Style > Subsection 11 Correct and Preferred Usage > 11.10 Inclusive Language > 11.10.4 Disabilities:

According to the Americans with Disabilities Act (<http://www.usdoj.gov/crt/ada/>), "a disability exists when an individual has any physical or psychological illness that 'substantially limits' a major life activity, such as walking, learning, breathing, working, or participating in community activities.'

Avoid labeling (and thus equating) people with their disabilities or diseases (eg, the blind, schizophrenics, epileptics). Instead, put the person first. Avoid describing persons as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from, stricken with, maimed). Avoid euphemistic descriptors such as physically challenged or special. Avoid metaphors that may be inappropriate and insensitive (blind to the truth, deaf to the request). For similar reasons, some publications avoid the term double-blind when referring to a study's methodology.

Note: Some manuscripts use certain phrases many times, and changing, for example, "AIDS patients" to "persons with AIDS" at every occurrence may result in awkward and stilted text. In such cases, the adjectival form may be used.

RELEVANT AMA POLICY

Person-First Language for Obesity H-440.821

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

(Policy Timeline: Res. 402, A-17 Modified: Speakers Rep., I-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-19)

Introduced by: Resident and Fellow Section

Subject: Delegation of Informed Consent

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, The process of witnessed informed consent is a vital prerequisite to any invasive
2 procedure or treatment, and constitutes a detailed back-and-forth discussion between the
3 healthcare team and the patient regarding specific risks, benefits, indications and alternatives of
4 that particular procedure or treatment; and

5
6 Whereas, Many physician groups and departments of physicians (particularly, specialists and
7 subspecialists) frequently work as a well-organized "team" in order to better care for the patient
8 and to improve the efficiency of patient care; and

9
10 Whereas, Allowing other qualified members of the health care team to participate in the
11 informed care process may provide the patient with more information, more opportunities to ask
12 questions and, ultimately, to be able to make an informed decision; and

13
14 Whereas, There are many situations when it is impractical to prohibit other competent members
15 of the health care team (residents, nurses, physician assistants) to participate in the informed
16 consent process; and

17
18 Whereas, The process of obtaining informed consent is a vital component in residency training
19 to produce a competent independent physician; and

20
21 Whereas, A 2017 Pennsylvania Supreme Court ruling (*Shinal v. Toms*) mandated that a
22 physician may not delegate to others his or her obligation to provide sufficient information to
23 obtain a patient's informed consent¹; and

24
25 Whereas, The Pennsylvania Supreme Court further stated in its judgment that the duty of
26 informed consent is a non-delegable duty owed by the physician conducting the surgery or
27 treatment; and

28
29 Whereas, This legal ruling may lead to a precedent with potential devastating and adverse
30 unintended consequences to patient health by causing unnecessary and potentially harmful
31 delays across the country; therefore be it

32
33 RESOLVED, That our American Medical Association in cooperation with other relevant
34 stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain
35 informed consent to another provider that has knowledge of the patient, the patient's condition,
36 and the procedures to be performed on the patient (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA study the implications of the *Shinal v. Toms* ruling and its potential
2 effects on the informed consent process. (Directive to Take Action)

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

Received: 05/01/19

References:

1. *Shinal v. Toms*, 2017 WL 2655387, at *17 (Pa. June 20, 2017).

RELEVANT AMA POLICY

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patients authorization or agreement to undergo a specific medical intervention. In seeking a patients informed consent (or the consent of the patients surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patients ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patients preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patients (or surrogates) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patients surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951

Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.

Citation: (Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10)

Informed Consent and Decision-Making in Health Care H-140.989

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to

assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-19)

Introduced by: Minority Affairs Section
GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Preventing Anti-Transgender Violence

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, A recent event has increased attention on violent crimes reported by the Lesbian,
2 Gay, Bisexual, Transgender, and Questioning (LGBTQ) or gender non-conforming communities
3 yet most media outlets have failed to accurately educate the public regarding the reality of the
4 discrimination and physical dangers faced by members of the LGBTQ community,¹⁻⁷ especially
5 Black transgender people and other transgender people of color; and
6
7 Whereas, Transgender individuals are people whose gender identity or gender expression
8 differs from their sex assigned at birth;⁸ and
9
10 Whereas, Transgender people who are People of Color, disabled, female identified, or a
11 member of another oppressed group may struggle with discrimination on multiple levels;^{9,10} and
12
13 Whereas, Violence against transgender people is often underreported due to transphobia and
14 mistrust of law enforcement;¹¹ and
15
16 Whereas, In 2013, the Human Rights Campaign published its first report that tracked fatal
17 violence against transgender people in the US and published its most recent report in 2018; and
18
19 Whereas, In the past six years of reporting by the Human Rights Campaign, 80% of all known
20 transgender homicide victims were transgender women of color, 69% were Black transgender
21 women; and
22
23 Whereas, Since 2013, at least 128 transgender women, transgender men, and non-binary
24 people (people whose gender is not male or female) have been killed across 32 states and 87
25 cities in the US;¹¹ and
26
27 Whereas, In 2017, there were 29 homicides of transgender people in the US reported in the
28 media, the highest number ever recorded, in addition to many more that were not publicly
29 known; and
30
31 Whereas, In 2018, advocates tracked at least 226 deaths of transgender people in the US due
32 to fatal violence, 82% of whom were transgender women of color and 73% of whom were Black
33 transgender women;¹¹ and
34
35 Whereas, In the summer of 2018, violent attacks claimed the lives of nine Black transgender
36 women in the span of only 10 weeks; and

1 Whereas, The Federal Bureau of Investigation reported a 17% increase in hate crime reports in
2 2017 compared to 2016 data, a rise for the third consecutive year;¹² and

3
4 Whereas, Of the more than 7,100 hate crimes reported in 2017, the Federal Bureau of
5 Investigation concluded nearly three out of five were motivated by race and ethnicity; and

6
7 Whereas, Numerous studies have found that transgender people, especially transgender people
8 of color, face high rates of sexual assault, intimate partner violence, and other non-fatal
9 violence; and

10
11 Whereas, The largest survey to date of transgender individuals in the United States, the 2015
12 US Transgender Survey, found that 13% of all respondents reported being physically assaulted
13 in the previous year; 47% reported ever experiencing sexual assault, including 10% in the
14 previous year; and 35% reported ever experiencing physical violence from an intimate partner;¹³
15 and

16
17 Whereas, The physical risks faced by transgender individuals can have long and short-term
18 negative impacts on the physical and mental health of these individuals, survivors, their
19 communities, and the nation as a whole; therefore be it

20
21 RESOLVED, That our American Medical Association partner with other medical organizations
22 and stakeholders to immediately increase efforts to educate the general public, legislators, and
23 members of law enforcement using verified data related to the hate crimes against transgender
24 individuals highlighting the disproportionate number of Black transgender women who have
25 succumbed to violent deaths (Directive to Take Action); and be it further

26
27 RESOLVED, That our AMA advocate for federal, state, and local law enforcement agencies to
28 consistently collect and report data on hate crimes, including victim demographics, to the FBI;
29 for the federal government to provide incentives for such reporting; and for demographic data on
30 an individual's birth sex and gender identity be incorporated into the National Crime
31 Victimization Survey and the National Violent Death Reporting System, in order to quickly
32 identify positive and negative trends so resources may be appropriately disseminated (Directive
33 to Take Action); and be it further

34
35 RESOLVED, That our AMA advocate for a central law enforcement database to collect data
36 about reported hate crimes that correctly identifies an individual's birth sex and gender identity,
37 in order to quickly identify positive and negative trends so resources may be appropriately
38 disseminated (Directive to Take Action); and be it further

39
40 RESOLVED, That our AMA advocate for stronger law enforcement policies regarding
41 interactions with transgender individuals to prevent bias and mistreatment and increase
42 community trust (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA advocate for local, state, and federal efforts that will increase
45 access to mental health treatment and that will develop models designed to address the health
46 disparities that LGBTQ individuals experience (Directive to Take Action); and be it further

47
48 RESOLVED, That our AMA issue a press release following the conclusion of the annual House
49 of Delegates meeting with updates to be published in both scientific and mainstream
50 publications regarding the prevalence of physical and mental health conditions and barriers
51 faced by the LGBTQ community. (Directive to Take Action)

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

Received: 05/09/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-19)

Introduced by: Minority Affairs Section

Subject: References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, The concept of protection against discrimination or harassment is not controversial,
2 however, generally accepted, standard language for protected classes or groups does not exist
3 among national organizations; and
4

5 Whereas, American Medical Association policy (and therefore Policy Finder) has multiple,
6 inconsistent references with variable language regarding protection against discrimination or
7 harassment against populations; therefore be it
8

9 RESOLVED, That our American Medical Association undertake a study to identify all
10 discrimination and harassment references in AMA policies and the code of ethics, noting when
11 the language is consistent and when it is not (Directive to Take Action); and be it further
12

13 RESOLVED, That our AMA research language and terms used by other national organizations
14 and the federal government in their policies on discrimination and harassment (Directive to Take
15 Action); and be it further
16

17 RESOLVED, That our AMA present the preliminary study results the Minority Affairs Section,
18 the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach
19 consensus on optimal language to protect vulnerable populations including racial and ethnic
20 minorities, sexual and gender minorities, and women, from discrimination and harassment
21 (Directive to Take Action); and be it further
22

23 RESOLVED, That our American Medical Association produce a report within 18 months with
24 study results and recommendations. (Directive to Take Action)

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

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-19)

Introduced by: New Mexico

Subject: Covenants Not to Compete

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Covenants not to compete have been used to force physicians to leave communities
2 if they leave hospital employment; and
3
4 Whereas, Recruiting and promoting new partners, building their referral bases, and purchasing
5 necessary equipment is a significantly expensive undertaking; and
6
7 Whereas, Practices endure significant financial harm when a hospital can lure a partner away,
8 and a requirement to pay liquidated damages when that happens mitigates the financial harm
9 without requiring the partner to leave the community; and
10
11 Whereas, New Mexico passed a statute that prohibits covenants not to compete for employed
12 physicians but allows for liquidated damages to be paid when a partner who is a part owner in a
13 practice is lured away by a competing hospital system; and
14
15 Whereas, The New Mexico statute is a model that could be used by the AMA Council on
16 Legislation as an example for other states; and
17
18 Whereas, The AMA Council on Ethical and Judicial Affairs opposes covenants not to compete in
19 all circumstances; therefore be it
20
21 RESOLVED, That our American Medical Association consider as the basis for model legislation
22 the New Mexico statute allowing a requirement that liquidated damages be paid when a
23 physician partner who is a part owner in practice is lured away by a competing hospital system
24 (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their
27 blanket opposition to covenants not to compete in the case of a physician partner who is a part
28 owner of a practice, in light of the protection that liquidated damages can confer to independent
29 physician owned partnerships, and because a requirement to pay liquidated damages does not
30 preclude a physician from continuing to practice in his or her community. (Directive to Take
31 Action)

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

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-19)

Introduced by: Michigan

Subject: Mature Minor Consent to Vaccinations

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, Vaccines have been one of the most effective methods of infectious disease control in
2 the past century, preventing 732,000 premature deaths in children born in the United States
3 between 1994 and 2013; and
4
- 5 Whereas, One of the goals of Healthy People 2020 is to increase immunization rates, targeting
6 a reduction in the incidence of 17 vaccine-preventable diseases in the United States; and
7
- 8 Whereas, There have been several recent well-publicized outbreaks of vaccine-preventable
9 illnesses such as measles, mumps, and pertussis in the United States, including the 2018
10 Michigan measles outbreak; and
11
- 12 Whereas, The prevalence of unvaccinated pediatric patients is rising in the United States, and
13 many children are unvaccinated due to parental distrust of vaccines; and
14
- 15 Whereas, Despite legislative efforts to regulate opt-out waivers for vaccinations, the Michigan
16 immunization waiver rate remains higher than three percent for both kindergarten and eighth
17 grade students, with greater than 70 percent of those waivers for philosophical rather than
18 religious or medical reasons; and
19
- 20 Whereas, A 2018 study found that three of the nation's 14 metropolitan "hotspots" for non-
21 medical exemption from vaccination are located in Michigan--Troy, Warren, and Detroit--
22 demonstrating a high risk of vaccine-preventable disease outbreaks; and
23
- 24 Whereas, Declining vaccination rates increase the probability of outbreaks of vaccine-
25 preventable diseases, and states with more opportunities for vaccination exemption have more
26 measles outbreaks; and
27
- 28 Whereas, Unvaccinated adolescents report interest in receiving vaccines to prevent against
29 common childhood illnesses; and
30
- 31 Whereas, Federal law does not require parental consent for vaccinations and many states,
32 including Michigan, do not have comprehensive statutes surrounding vaccination policy; and
33
- 34 Whereas, Minors in the majority of states, including Michigan, are able to consent to some
35 mental health services, sexually transmitted disease testing and treatment, birth control, and
36 pregnancy related care; and

1 Whereas, Adolescents in 21 states do not require parental consent for treatment of reportable
2 diseases, which include hepatitis B, measles, mumps, and pertussis; and
3

4 Whereas, The inability for minors to provide consent to vaccinations has been cited as a barrier
5 to vaccination rates; and
6

7 Whereas, An American Academy of Pediatrics' article proposed minor consent to vaccination
8 via the mature minor doctrine, a widely accepted legal concept allowing "certain older minors
9 who have the capacity to give informed consent to do so for care that is within the mainstream
10 of medical practice, not high risk, and provided in a non-negligent manner;" and
11

12 Whereas, Vaccinations are safe, effective, low-risk, and necessary for a multi-faceted,
13 comprehensive approach to public health and it is thus in the interest of the medical community
14 and concerned citizens to promote access to vaccination; and
15

16 Whereas, Allowing mature minors an avenue to provide for their own personal health, when
17 they have no medical contraindications to the vaccinations and are given the same
18 comprehensive vaccine information as consenting adults, abides by the same ethical standards
19 as other procedures allowed for in Michigan without parental consent; therefore be it
20

21 RESOLVED, That our American Medical Association amend the policy H-440.830, "Education
22 and Public Awareness on Vaccine Safety and Efficacy," by addition and deletion as follows:
23

24 Our AMA (a) encourages the development and dissemination of evidence-based
25 public awareness campaigns aimed at increasing vaccination rates; (b) encourages
26 the development of educational materials that can be distributed to patients and their
27 families clearly articulating the benefits of immunizations and highlighting the
28 exemplary safety record of vaccines; (c) supports the development and evaluation, in
29 collaboration with health care providers, of evidence-based educational resources to
30 assist parents in educating and encouraging other parents who may be reluctant to
31 vaccinate their children; (d) encourages physicians and state and local medical
32 associations to work with public health officials to inform those who object to
33 immunizations about the benefits of vaccinations and the risks to their own health and
34 that of the general public if they refuse to accept them; (e) will promote the safety and
35 efficacy of vaccines while rejecting claims that have no foundation in science; ~~and~~
36 (f) supports state policies allowing adolescents to provide their own consent for
37 vaccination and encourages state legislatures to establish comprehensive vaccine and
38 minor consent policies; and (g) will continue its ongoing efforts with other immunization
39 advocacy organizations to assist physicians and other health care professionals in
40 effectively communicating to patients, parents, policy makers, and the media that
41 vaccines do not cause autism and that decreasing immunization rates have resulted in
42 a resurgence of vaccine-preventable diseases and deaths. (Modify Current HOD
43 Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (f) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link

between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Citation: Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17

Achieving National Adolescent Immunization Goals H-440.901

Our AMA: (1) endorses the National Adolescent Vaccine Coverage Goals; and (2) endorses the collaboration of physicians, public health officials and legislators in each state to carry out strategies that ensure the National Adolescent Vaccine Coverage Goals are met.

Citation: Res. 411, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Childhood Immunizations H-60.969

1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

Citation: (Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13

Confidential Health Services for Adolescents H-60.965

Our AMA:

- (1) reaffirms that confidential care for adolescents is critical to improving their health;
- (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
- (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
- (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
- (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
- (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective

jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-19)

Introduced by: Medical Student Section

Subject: Improving Body Donation Regulation

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, Body donation is essential to medical-surgical education, continuing education
2 programs, clinical practice, and research, even as new virtual technology emerges¹⁻¹⁷; and
3
4 Whereas, Research and education conducted on donated bodies is beneficial to patients,
5 society, and the medical profession^{14,17,18,19,20,21}; and
6
7 Whereas, Body donation, transplant tissue donation, and vascular organ donation are all
8 examples of how an individual person may donate part or all of his or her body to the institutions
9 of science and medicine^{22,23,24}; and
10
11 Whereas, Transplant tissue and vascular organ donations are heavily regulated on a federal
12 level by the Food and Drug Administration (FDA) and the Health Resources Service
13 Administration (HRSA), respectively^{25,26,27}; and
14
15 Whereas, Body donation is classified as neither transplant tissue donation nor vascular organ
16 donation and is thus not regulated by either the FDA or HRSA, creating a gap in federal
17 oversight and resulting in state- and institutional-level regulation^{16,29,30}; and
18
19 Whereas, As a result, body donation practices lack transparency and consistency, creating
20 loopholes between federal, state, and institutional policy^{16,29,30,31,32}; and
21
22 Whereas, The lack of consistent and appropriate monitoring of bodies and body parts results in
23 lost tissues and incorrectly returned remains^{30,33}; and
24
25 Whereas, Lack of regulation allows for market incentives to drive unethical body part
26 acquisitions, requiring each individual institution, research team, and health care provider to set
27 their own ethical bar^{30,31,32}; and
28
29 Whereas, Lack of regulation allows misleading marketing that focuses on financial incentives
30 (e.g., free cremation) and does not clearly explain how donated bodies are used, which leads to
31 an incongruence between donor/family wishes and understanding, and the resulting use of their
32 bodies^{29,32,34}; and
33
34 Whereas, The AMA supports federal oversight for processes involving tissue and organ
35 donation to the medical profession through existing Policy (H-370.988); and
36
37 Whereas, The AMA Code of Ethics has established importance of removing potential financial
38 incentives for organ donation (6.1.3), but there are no analogous policies for body donation; and

1 Whereas, Multiple institutional and professional organizational guidelines for ethical and
2 productive body donation programs exist that could inform federal regulation³⁶; therefore be it
3
4 RESOLVED, That our American Medical Association recognize the need for ethical,
5 transparent, and consistent body donation regulations. (New HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

E-6.1.3 Studying Financial Incentives for Cadaveric Organ Donation

Physicians' ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence. Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

- (a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.
- (b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.
- (c) Has been developed in consultation with the population among whom it is to be carried out.
- (d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.
- (e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

Regulation of Tissue Banking H-370.988

Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues.

Citation: BOT Rep. E, I-89; Reaffirmed: Sunset Report, A-00; Modified and Appended, CSA Rep. 5, I-01; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

State Regulation and Licensing of Human Tissue Banks H-370.989

Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements.

Citation: (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01; Reaffirmed: CSAPH Rep. 1, A-11

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Citation: (CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12

Organ Donation D-370.985

Our AMA will study potential models for increasing the United States organ donor pool.

Citation: Res. 1, A-14; Reaffirmed in lieu of Res. 5, I-14; Reaffirmed in lieu of: Res. 002, I-16

Ethical Procurement of Organs for Transplantation H-370.967

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.

Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-19)

Introduced by: Medical Student Section

Subject: Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, In 2017 it became policy that unaccompanied immigrant minors – children that enter
2 the United States in family units and those that cross individually – must be placed under the
3 custody of Office Refugee Resettlement (ORR) of the Department of Health and Human
4 Services (HHS) ¹; and
5
6 Whereas, In 2017, 40,810 unaccompanied immigrant children were referred to ORR, where the
7 average length of stay was 41 days²; and
8
9 Whereas, Children in ORR custody frequently receive medical and mental health services
10 during their detainment³; and
11
12 Whereas, Confidential medical and psychological records and social work case files from ORR
13 are increasingly presented in immigration court as evidence for deportation or further
14 detainment^{4,5}; and
15
16 Whereas, Before a child reaches the age of 18 they cannot exercise their own HIPAA rights
17 without the signature of a parent or guardian, and children in detainment are separated from
18 their parents, and therefore do not have access to their own HIPAA rights⁵⁻⁷; and
19
20 Whereas, Breaches in patient confidentiality, or the perceived threat thereof, create distrust in
21 the healthcare system and lead to patients delaying or forgoing medical care, particularly in
22 immigrant populations⁸⁻¹⁰; and
23
24 Whereas, Undocumented children forcibly separated from parents at the US border
25 have been shown to be at increased risk for post-traumatic stress disorder, anxiety, depression,
26 aggression and suicidal ideation^{11,12}; and
27
28 Whereas, Separating children from their parents during development has been linked with later
29 risk of criminality and mental health issues such as bipolar disorder and schizophrenia¹³; and
30
31 Whereas, Existing AMA policy calls for our AMA to “work with medical societies and all
32 clinicians to work together with other child-serving sectors to ensure that new immigrant children
33 receive timely and age-appropriate services that support their health and well-being” (D-60.968);
34 and
35
36 Whereas, Existing AMA policy directs our AMA to “recommend the U.S. Immigrations and
37 Customs Enforcement refrain from partnerships with private institutions whose facilities do not

1 meet the standards of medical, mental, and dental care as guided by the National Commission
2 on Correctional Health Care” (D-350.983); and

3
4 Whereas, Existing AMA policy instructs our AMA to “support protections that prohibit... law
5 enforcement agencies from utilizing information from medical records to pursue immigration
6 enforcement actions against patients who are undocumented” (H-315.966); therefore be it

7
8 RESOLVED, That our American Medical Association advocate that healthcare services
9 provided to minors in immigrant detention focus solely on the health and well-being of the
10 children (Directive to Take Action); and be it further

11
12 RESOLVED, That our AMA condemn the use of confidential medical and psychological records
13 and social work case files as evidence in immigration courts without patient consent. (Directive
14 to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968

Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.

Citation: (Res. 8, I-14

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S.

Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Citation: Res. 017, A-17

Patient and Physician Rights Regarding Immigration Status H-315.966

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

Citation: Res. 018, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-19)

Introduced by: Medical Student Section

Subject: Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

-
- 1 Whereas, Professional medical associations serve physicians and patients by improving
2 physician knowledge and skill, engaging in scholarly activity, and working to promote the public
3 health¹; and
4
- 5 Whereas, Patient advocacy groups provide education, outreach, and support services to
6 patients affected by a medical condition²; and
7
- 8 Whereas, These positive contributions can be affected by financial conflicts of interest,
9 especially in cases where for-profit companies' payments comprise a significant proportion of a
10 professional medical association or a patient advocacy group's operating budget^{2,5}; and
11
- 12 Whereas, A 2017 study of patient advocacy groups revealed that disclosure practices around
13 funding sources and amounts, uses of funding, and corporate connections of management were
14 inconsistent⁴; and
15
- 16 Whereas, The study showed 83% of the studied patient advocacy groups received financial
17 support from drug and biotechnology companies and at least 39% had a current or former
18 industry executive on the governing board, indicating a significant conflict of interest⁴; and
19
- 20 Whereas, Patient advocacy groups motivated by their conflicts of interest may advocate for
21 drugs to enter the marketplace prior to sufficient evidence or may advocate for insurance
22 coverage of these drugs despite minimal or no benefits²; and
23
- 24 Whereas, Professional medical associations are also susceptible to conflict of interest as some
25 depend on industry funding for a significant portion of their operating budget, ranging from 25%
26 to 75% in funding from drug and device companies^{5,6}; and
27
- 28 Whereas, Some professional medical associations set guidelines, and the National Academy of
29 Medicine has recommended limiting authors of clinical guidelines to receive less than 50% of
30 their funding from industry financial ties⁷; and
31
- 32 Whereas, Though the National Academy of Medicine recommended a disclosure law to cover
33 industry payments to patient advocacy groups and professional medical associations, such a
34 provision was not included in the Physician Payments Sunshine Act of 2010⁴; and
35
- 36 Whereas, Disclosure engenders the public trust by providing transparency about financial
37 relationships that a physician, physician organization, or professional medical organization has

1 with industry and enabling the public to weigh that influence on the organization's practices⁵;
2 and
3

4 Whereas, While the AMA Code of Medical Ethics 11.2.1 and 11.2.4 address transparency of
5 individual physicians in healthcare settings, the Code does not encompass collective
6 transparency beyond the healthcare setting of professional medical associations and patient
7 advocacy organizations; therefore be it
8

9 RESOLVED, That our American Medical Association support guidelines for members of the
10 Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships,
11 and other financial transactions by industry and commercial stakeholders. (New HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

E-11.2.1 Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

- (a) Are transparent.
- (b) Reflect input from key stakeholders, including physicians and patients.
- (c) Recognize that over reliance on financial incentives may undermine physician professionalism.
- (d) Ensure ethically acceptable incentives that:
 - (i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;

- (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
 - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
 - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
 - (e) Encourage, rather than discourage, physicians (and others) to:
 - (i) provide care for patients with difficult to manage medical conditions;
 - (ii) practice at their full capacity, but not beyond.
 - (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
 - (g) Are routinely monitored to:
 - (i) identify and address adverse consequences;
 - (ii) identify and encourage dissemination of positive outcomes.
- All physicians should:
- (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
 - (i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

E-11.2.4 Transparency in Health Care

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care. Although health plans and other entities may have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians share in this responsibility.

Individually, physicians should:

- (a) Disclose any financial and other factors that could affect the patient's care.
- (b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.
- (c) Encourage patients to be aware of the provisions of their health plan.

Collectively, physicians should advocate that health plans with which they contract disclose to patient-members:

- (d) Plan provisions that limit care, such as formularies or constraints on referrals.
- (e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.
- (f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physician treatment recommendations.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

9.6.2 Gifts to Physicians from Industry

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing or being perceived to bias - professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

(a) Decline cash gifts in any amount from an entity that has a direct interest in physician treatment recommendations.

(b) Decline any gifts for which reciprocity is expected or implied.

(c) Accept an in-kind gift for the physician's practice only when the gift:

(i) will directly benefit patients, including patient education; and

(ii) is of minimal value.

(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:

(i) the program identifies recipients based on independent institutional criteria; and

(ii) funds are distributed to recipients without specific attribution to sponsors.

[AMA Principles of Medical Ethics: II](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

Principles on Corporate Relationships G-630.040

The House of Delegates adopts the following revised principles on Corporate Relationships. The Board will review them annually and, if necessary, make recommendations for revisions to be presented to the House of Delegates.

(1) **GUIDELINES FOR AMA CORPORATE RELATIONSHIPS.** Principles to guide AMA's relationships with corporate America were adopted by our AMA House of Delegates at its December 1997 meeting and slightly modified at the June 1998 meeting. Subsequently, they have been edited to reflect the recommendations from the Task Force on Association/Corporate Relations, including among its members experts external to our AMA. Minor edits were also adopted in 2002. The following principles are based on the premise that in certain circumstances, our AMA should participate in corporate arrangements when guidelines are met, which can further our AMA's core strategic focus, retain AMA's independence, avoid conflicts of interest, and guard our professional values.

(2) **OVERVIEW OF PRINCIPLES.** The AMA's principles to guide corporate relationships have been organized into the following categories: General Principles that apply to most situations; Special Guidelines that deal with specific issues and concerns; Organizational Review that outlines the roles and responsibilities of the Board of Trustees, AMA Management and other staff units. These guidelines should be reviewed over time to assure their continued relevance to the policies and operations of our AMA and to our business environment. The principles should serve as a starting point for anyone reviewing or developing AMA's relationships with outside groups.

(3) **GENERAL PRINCIPLES.** Our AMA's vision and values statement and strategic focus should provide guidance for externally funded relationships. Relations that are not motivated by the association's mission threaten our AMA's ability to provide representation and leadership for the profession. (a) Our AMA's vision and values and strategic focus ultimately must determine whether a proposed relationship is appropriate for our AMA. Our AMA should not have relationships with organizations or industries whose principles, policies or actions obviously conflict with our AMA's vision and values. For example, relationships with producers of products that harm the public health (e.g., tobacco) are not appropriate for our AMA. Our AMA will proactively choose its priorities for external relationships and collaborate in those that fulfill these priorities. (b) The relationship must preserve or promote trust in our AMA and the medical profession. To be effective, medical professionalism requires the public's trust. Corporate relationships that could undermine the public's trust in our AMA or the profession are not acceptable. For example, no relationship should raise questions about the scientific content of our AMA's health information publications, AMA's advocacy on public health issues, or the truthfulness of its public statements. (c) The relationship must maintain our AMA's objectivity with respect to health issues. Our AMA accepts funds or royalties from external organizations only if acceptance does not pose a conflict of interest and in no way impacts the objectivity of the association, its members, activities, programs, or employees. For example, exclusive relationships with manufacturers of health-related products marketed to the public could impair our AMA's objectivity in promoting the health of America. Our AMA's objectivity with respect to health issues should not be biased by external relationships. (d) The activity must provide benefit to the public's

health, patients' care, or physicians' practice. Public education campaigns and programs for AMA or Federation members are potentially of significant benefit. Corporate-supported programs that provide financial benefits to our AMA but no significant benefit to the public or direct professional benefits to AMA or Federation members are not acceptable. In the case of member benefits, external relations must not detract from AMA's professionalism.

(4) SPECIAL GUIDELINES. The following guidelines address a number of special situations where our AMA cannot utilize external funding. There are specific guidelines already in place regarding advertising in publications. (a) Our AMA will provide health and medical information, but should not involve itself in the production, sale, or marketing to consumers of products that claim a health benefit. Marketing health-related products (e.g., pharmaceuticals, home health care products) undermines our AMA's objectivity and diminishes its role in representing healthcare values and educating the public about their health and healthcare. (b) Activities should be funded from multiple sources whenever possible. Activities funded from a single external source are at greater risk for inappropriate influence from the supporter or the perception of it, which may be equally damaging. For example, funding for a patient education brochure should be done with multiple sponsors if possible. For the purposes of this guideline, funding from several companies, but each from a different and non-competing industry category (e.g., one pharmaceutical manufacturer and one health insurance provider), does not constitute multiple-source funding. Our AMA recognizes that for some activities the benefits may be so great, the harms so minimal, and the prospects for developing multiple sources of funding so unlikely that single-source funding is a reasonable option. Even so, funding exclusivity must be limited to program only (e.g., asthma conference) and shall not extend to a therapeutic category (e.g., asthma). The Board should review single-sponsored activities prior to implementation to ensure that: (i) reasonable attempts have been made to locate additional sources of funds (for example, issuing an open request for proposals to companies in the category); and (ii) the expected benefits of the project merit the additional risk to our AMA of accepting single-source funding. In all cases of single-source funding, our AMA will guard against conflict of interest. (c) The relationship must preserve AMA's control over any projects and products bearing our AMA name or logo. Our AMA retains editorial control over any information produced as part of a corporate/externally funded arrangement. When an AMA program receives external financial support, our AMA must remain in control of its name, logo, and AMA content, and must approve all marketing materials to ensure that the message is congruent with our AMA's vision and values. A statement regarding AMA editorial control as well as the name(s) of the program's supporter(s) must appear in all public materials describing the program and in all educational materials produced by the program. (This principle is intended to apply only to those situations where an outside entity requests our AMA to put its name on products produced by the outside entity, and not to those situations where our AMA only licenses its own products for use in conjunction with another entity's products.) (d) Relationships must not permit or encourage influence by the corporate partner on our AMA. An AMA corporate relationship must not permit influence by the corporate partner on AMA policies, priorities, and actions. For example, agreements stipulating access by corporate partners to the House of Delegates or access to AMA leadership would be of concern. Additionally, relationships that appear to be acceptable when viewed alone may become unacceptable when viewed in light of other existing or proposed activities. (e) Participation in a sponsorship program does not imply AMA's endorsement of an entity or its policies. Participation in sponsorship of an AMA program does not imply AMA approval of that corporation's general policies, nor does it imply that our AMA will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. Our AMA's name and logo should not be used in a manner that would express or imply an AMA endorsement of the corporation, its policies and/or its products. (f) To remove any appearance of undue influence on the affairs of our AMA, our AMA should not depend on funding from corporate relationships for core governance activities.

Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates, the Board of Trustees and Council meetings could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of our AMA. (g) Funds from corporate relationships must not be used to support political advocacy activities. A full and effective separation should exist, as it currently does, between political activities and corporate funding. Our AMA should not advocate for a particular issue because it has received funding from an interested corporation. Public concern would be heightened if it appeared that our AMA's advocacy agenda was influenced by corporate funding.

(5) ORGANIZATIONAL REVIEW. Every proposal for an AMA corporate relationship must be thoroughly screened prior to staff implementation. AMA activities that meet certain criteria requiring further review are forwarded to a committee of the Board of Trustees for a heightened level of scrutiny. (a) As part of its

annual report on the AMA's performance, activities, and status, the Board of Trustees will present a summary of the AMA's corporate arrangements to the House of Delegates at each Annual Meeting. (b) Every new AMA Corporate relationship must be approved by the Board of Trustees, or through a procedure adopted by the Board. Specific procedures and policies regarding Board review are as follows: (i) The Board routinely should be informed of all AMA corporate relationships; (ii) Upon request of two dissenting members of the CRT, any dissenting votes within the CRT, and instances when the CRT and the Board committee differ in the disposition of a proposal, are brought to the attention of the full Board; (iii) All externally supported corporate activities directed to the public should receive Board review and approval; (iv) All activities that have support from only one corporation except patient materials linked to CME, within an industry should either be in compliance with ACCME guidelines or receive Board review; and (f) All relationships where our AMA takes on a risk of substantial financial penalties for cancellation should receive Board review prior to enactment. (c) The Executive Vice President is responsible for the review and implementation of each specific arrangement according to the previously described principles. The Executive Vice President is responsible for obtaining the Board of Trustees authorization for externally funded arrangements that have an economic and/or policy impact on our AMA. (d) The Corporate Review Team reviews corporate arrangements to ensure consistency with the principles and guidelines. (i) The Corporate Review Team is the internal, cross-organizational group that is charged with the review of all activities that associate the AMA's name and logo with that of another entity and/or with external funding. (ii) The Review process is structured to specifically address issues pertaining to AMA's policy, ethics, business practices, corporate identity, reputation and due diligence. Written procedures formalize the committee's process for review of corporate arrangements. (iii) All activities placed on the Corporate Review Team agenda have had the senior manager's review and consent, and following CRT approval will continue to require the routine approvals of the Office of Finance and Office of the General Counsel. (iv) The Corporate Review Team reports its findings and recommendations directly to a committee of the Board. (e) Our AMA's Office of Risk Management in consultation with the Office of the General Counsel will review and approve all marketing materials that are prepared by others for use in the U.S. and that bear our AMA's name and/or corporate identity. All marketing materials will be reviewed for appropriate use of AMA's logos and trademarks, perception of implied endorsement of the external entity's policies or products, unsubstantiated claims, misleading, exaggerated or false claims, and reference to appropriate documentation when claims are made. In the instance of international publishing of JAMA and the Archives, our AMA will require review and approval of representative marketing materials by the editor of each international edition in compliance with these principles and guidelines. (6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS. (a) Organizational culture has a profound impact on whether and how AMA corporate relationships are pursued. AMA activities reflect on all physicians. Moreover, all physicians are represented to some extent by AMA actions. Thus, our AMA must act as the professional representative for all physicians, and not merely as an advocacy group or club for AMA members. (b) As a professional organization, our AMA operates with a higher level of purpose representing the ideals of medicine. Nevertheless, non-profit associations today do require the generation of non-dues revenues. Our AMA should set goals that do not create an undue expectation to raise increasing amounts of money. Such financial pressures can provide an incentive to evade, minimize, or overlook guidelines for fundraising through external sources. (c) Every staff member in the association must be accountable to explicit ethical standards that are derived from the vision, values, and focus areas of the Association. In turn, leaders of our AMA must recognize the critical role the organization plays as the sole nationally representative professional association for medicine in America. AMA leaders must make programmatic choices that reflect a commitment to professional values and the core organizational purpose.

BOT Rep. 20, A-99 Consolidated: CLRPD Rep. 3, I-01 Modified: CLRPD Rep. 1, A-03 Modified: CCB/CLRPD Rep. 3, A-12

Preservation of Political Advocacy by Nonprofit Organizations H-270.968

The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.

Citation: Res. 216, A-96; Reaffirmed: BOT Rep. 34, A-06; Reaffirmed: BOT Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-19)

Introduced by: Medical Student Section

Subject: Opposing Mandated Reporting of People Who Question Their Gender Identity

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Transgender and gender nonconforming people are defined by the American
2 Psychological Association as those who have a gender identity that is not fully aligned with their
3 sex assigned at birth¹; and
4

5 Whereas, An estimated 153,300 of US children age 13-17 years old and 700,000 of US adults
6 identify as transgender or gender nonconforming²; and
7

8 Whereas, Compelled disclosure policies, including mandatory reporting laws, represent a
9 growing effort by federal, state, and institutional agencies to increase transparency regarding
10 abuses against vulnerable populations, but must be balanced against the constitutionality of
11 compelled speech by showing there is a compelling reason for the speech to be compelled³⁻⁵;
12 and
13

14 Whereas, Proposed Ohio House Bill 658 places explicit burden on educational and healthcare
15 professionals to ascertain parental consent before pursuing subsequent therapeutic intervention
16 for gender nonconforming minor patients⁶; and proposed constitutional amendment in Delaware
17 would change discrimination protections to require disclosure of a student's gender
18 identity/expression to parents before making accommodations in applicable educational
19 programs⁸; and
20

21 Whereas, Laws enacted in multiple states have been upheld in court which found that parents
22 have no right to choose a harmful treatment for their child and free speech could be regulated to
23 protect children from harmful or ineffective professional services^{9,10}; and
24

25 Whereas, Gender nonconformity is a major risk factor for school victimization among LGBTQ+
26 (lesbian, gay, bisexual, transgender, queer) youth and may also be a reason for gender
27 nonconforming youth to seek medical or mental health services^{11,12}; and
28

29 Whereas, The two most frequent reasons for LGBTQ+ homelessness--approximately forty
30 percent of homeless youth--are family rejection of sexual orientation or gender identity and
31 being forced out by parents because of sexual orientation or gender identity¹³; and
32

33 Whereas, Young LGBTQ+ adults who reported family rejection during adolescence were 8.4
34 times more likely to report having attempted suicide, 5.9 times more likely to report high levels
35 of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report
36 having engaged in unprotected sexual intercourse¹⁴; and

1 Whereas, Sixty-one percent of LGBTQ+ youth report being open about their sexual orientation
2 and/or gender identity at school¹⁵; and
3

4 Whereas, Twenty-six percent of LGBTQ+ youth do not want to disclose their sexual orientation
5 and/or gender identity to teachers out of fear that those teachers might then tell their parents
6 and that it would impact their education unnecessarily¹⁵; and
7

8 Whereas, Pursuant to existing AMA policy H-315.983, our AMA believes “patients' privacy
9 should be honored unless waived by the patient in a meaningful way or in rare instances when
10 strong countervailing interests in public health or safety justify invasions of patient privacy or
11 breaches of confidentiality, and then only when such invasions or breaches are subject to
12 stringent safeguards enforced by appropriate standards of accountability”; therefore be it
13

14 **RESOLVED**, That our American Medical Association oppose mandated reporting of youth who
15 question or express interest in exploring their gender identity. (New HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

2.2.2 Confidential Health Care for Minors

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and

delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decision-making authority for that care, physicians should:

- (a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:
 - (i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;
 - (ii) involving the patient's parent/guardian is necessary to avert serious harm to others;
 - (iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.
- (b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.
- (c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.
- (d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).
- (e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.
- (f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.
- (g) Consult experts when the patient's decision-making capacity is uncertain.
- (h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

[AMA Principles of Medical Ethics: IV](#)

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Issued: 2016

3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

- (a)...Minimize intrusion on privacy when the patients privacy must be balanced against other factors.
- (b)...Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
- (c)...Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

[AMA Principles of Medical Ethics: I.IV](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended
Issued: 2016

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) 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; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

Citation: Res. 05, A-16

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
 - (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
 - (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
 - (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
 - (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
 - (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against

individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and

policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18

Nondiscriminatory Policy for the Health Care Needs of LGBTQ 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.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

Confidential Health Services for Adolescents H-60.965

Our AMA:

- (1) reaffirms that confidential care for adolescents is critical to improving their health;
- (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
- (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
- (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This

discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);

(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;

(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(A-19)

Introduced by: Medical Student Section

Subject: Sexual and Gender Minority Populations in Medical Research

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

- 1 Whereas, In the United States, approximately eight million adults identify as lesbian, gay, or
2 bisexual, and 700,000 adults identify as transgender¹; and
3
- 4 Whereas, In 2016, the National Institute of Minority Health and Health Disparities, part of the
5 National Institutes of Health (NIH), designated sexual and gender minorities (SGM) as a health
6 disparity population for research purposes²; and
7
- 8 Whereas, In 2015, the NIH established a Sexual and Gender Minority Research Office that
9 provides funding earmarked for SGM-specific medical research^{3,4}; and
10
- 11 Whereas, There continues to be a paucity of research regarding health care issues and
12 integrated care interventions affecting lesbian, gay, bisexual, and transgender (LGBT)-identified
13 youth and older adults⁵⁻⁷; and
14
- 15 Whereas, Investigators failing to collect sexual preference data on study participants has been
16 identified as a barrier to detecting health trends among SGM populations⁸; and
17
- 18 Whereas, Despite the relative scarcity of studies that record SGM identifiers, research has
19 shown significant disparities between SGM groups and between those populations and the
20 general public, such as modifiable risk factors for cardiovascular disease, prevalence and
21 predictors of obesity, mental health and substance use disorders, sexually transmitted
22 infections, and suicidal ideation and suicidality⁹⁻¹⁶; and
23
- 24 Whereas, The U.S. Department of Health and Human Services' Office of Disease Prevention
25 and Health Promotion, as a part of the Healthy People 2020 initiative, set a goal of increasing
26 the number of states that include questions identifying sexual orientation and gender identity on
27 state level surveys and/or data systems¹⁷; and
28
- 29 Whereas, Collecting data on patients' sexual orientation and gender identity in the electronic
30 health record is supported by multiple sources, including the National Academy of Medicine's
31 2011 report on LGBT health, Healthy People 2020, the Affordable Care Act, and the Joint
32 Commission¹⁸; and
33
- 34 Whereas, Pursuant to existing AMA policy H-460.909, our AMA believes research priorities and
35 methodology should factor in any systematic variations in disease prevalence or response
36 across groups by race, ethnicity, gender, age, geography, and economic status; and
37
- 38 Whereas, Pursuant to existing AMA policy H-460.907, our AMA encourages research into
39 specific areas affecting the health of SGM populations; and

1 Whereas, Pursuant to existing AMA policy H-315.967, our AMA supports collection of patient
2 data that is inclusive of sexual orientation/gender identity in medical documentation and related
3 forms for research purposes, but our AMA is unclear in its position on collection of this data in
4 the context of research studies; therefore be it

5
6 RESOLVED, That our American Medical Association amend policy H-315.967, "Promoting
7 Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition
8 and deletion as follows:

9
10 **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical**
11 **Documentation**

12 Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current
13 gender identity, sexual orientation, and preferred gender pronoun(s) in medical
14 documentation and related forms, including in electronic health records, in a culturally-
15 sensitive and voluntary manner; and (2) will advocate for collection of patient data in
16 medical documentation and in medical research studies, according to current best
17 practices, that is inclusive of sexual orientation/gender identity sexual orientation, gender
18 identity, and other sexual and gender minority traits such as differences/disorders of sex
19 development for the purposes of research into patient and population health. (Modify
20 Current HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer 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, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ 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 LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ 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 sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy 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; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ 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 LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSA

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17
PH Rep. 01, I-18

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients H-460.907

Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients.

Citation: (Res. 512, A-11)

Comparative Effectiveness Research H-460.909

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

- A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.
- B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.
- C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.
- D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.
- E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.
- F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.
- G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.
- H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.
- I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to

physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

Citation: CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09; Reaffirmation I-10; Reaffirmed: CMS Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(A-19)

Introduced by: Medical Student Section

Subject: National Guidelines for Guardianship

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Guardianship is defined as a legal relationship created when a state court grants a
2 person or entity the authority to make decisions on behalf of an incapacitated individual
3 concerning his/her person or property^{1,2}; and
4

5 Whereas, Incapacity is defined as the inability “to meet essential requirement for physical
6 health, safety, and self-care even with appropriate technological assistance” (functional
7 incapacity) or the inability to “receive and evaluate information or make or communicate
8 decisions” (cognitive incapacity)^{3,4}; and
9

10 Whereas, A guardian is expected to direct an individual’s assets and benefits towards “food,
11 clothing, housing, medical care, personal items, and other immediate and reasonably
12 foreseeable needs”²; and
13

14 Whereas, Approximately 1.5 million adults in the U.S. are under the care of guardians⁵⁻⁷; and
15

16 Whereas, The U.S. Census Bureau estimated within the U.S. there were over 46 million
17 individuals aged 65 and older (2014) and that figure would double by year 2050¹; and
18

19 Whereas, Given the combined anticipated growth of the geriatric population and the prevalence
20 of neurodegenerative diseases, more comprehensive guardianship programs and standard
21 state-level guidelines are warranted to ensure continued delivery of quality care^{8,9}; and
22

23 Whereas, Guardianship programs are overseen by individual states’ laws, regulations, and court
24 systems and there is currently no nationwide system of guardianship in place^{1,2,10-13}; and
25

26 Whereas, In September 2016, only 12 states required certification of professional guardians
27 (who may range from family, friends, corporate professionals, or government officials), and in
28 many states, guardians are not required to receive any formal training^{6,14}; and
29

30 Whereas, In 2011, the Government Accountability Office (GAO) determined there was
31 widespread failure of guardians to faithfully execute their court-ordered duties including through
32 neglect, abuse, and financial exploitation, inadequate screening and training of, and insufficient
33 oversight of guardians after appointment^{2,15}; and
34

35 Whereas, Oversight and evaluation of guardians is often minimal, and courts and public
36 systems are commonly underfunded and understaffed which results in great difficulty enforcing
37 the minimal regulations and protections currently in place^{1,5,7,16}; and

1 Whereas, Improper granting of guardianship deprives individuals of civil liberties including their
2 right to self-determination, excludes them from the normal decision-making process, and
3 contributes to further isolation and erosion of actual and self-perceived abilities^{2,17,18}; and
4

5 Whereas, Poor collection and management of guardianship data across state governments and
6 court systems, in addition to the lack of guardian registries in many states have created barriers
7 to developing evidence-based regulatory and legislative solutions to abuses by guardians^{10,13};
8 and
9

10 Whereas, The lack of standardization for evaluating indications for guardianship in the
11 healthcare setting contributes to delays in process initiation, decreased prompt access to follow-
12 up services, and increased number of medically unnecessary admission days and total
13 expenses¹³; and
14

15 Whereas, Current AMA policy does not address the disparities in guardianship laws that have
16 enabled numerous cases of abuse and left vulnerable those they are meant to protect; therefore
17 be it
18

19 RESOLVED, That our American Medical Association collaborate with relevant stakeholders to
20 advocate for federal creation and adoption of national standards for guardianship programs,
21 appropriate program funding measures, and quality control measures. (Directive to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Elder Mistreatment D-515.985

Our AMA:

1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.
2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.
3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.
4. Encourages substantially more research in the area of elder mistreatment.
5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.
6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated.
7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation.

Citation: (CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13)

Elder Mistreatment H-515.961

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

Citation: CSAPH Rep. 7, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Health Care Costs of Violence and Abuse Across the Lifespan D-515.984

1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan.
2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse.
3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

Citation: Res. 431, A-08; Modified: CSAPH Rep. 01, A-18

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to

campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

(a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;

(b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;

(c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;

(d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;

(e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;

(f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization;

(g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves;

(h) Give due validation to the experience of victimization and of observed symptomatology as possible sequelae;

(i) Record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;

(j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities;

(b) allow competent adult victims to opt out of the reporting system if identifiers are required;

- (c) provide that reports be made to public health agencies for surveillance purposes only;
- (d) contain a sunset mechanism; and
- (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
- (6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
 - (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
 - (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
 - (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
 - (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
 - (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Citation: (CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09)

E-8.10 Preventing, Identifying and Treating Violence and Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients well-being, physicians individually should:

- (a) Become familiar with:
 - (i) how to detect violence or abuse, including cultural variations in response to abuse;
 - (ii) community and health resources available to abused or vulnerable persons;
 - (iii) public health measures that are effective in preventing violence and abuse;
 - (iv) legal requirements for reporting violence or abuse.
 - (b) Consider abuse as a possible factor in the presentation of medical complaints.
 - (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
 - (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in normal families, is a private matter best resolved without outside interference, or is caused by victims own actions.
 - (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
 - (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
 - (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
 - (i) inform patients about requirements to report;
 - (ii) obtain the patients informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patients refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
 - (h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
- Collectively, physicians should:
- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.

(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.

(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

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

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-19)

Introduced by: Medical Student Section

Subject: Support for Requiring Investigations into Deaths of Children in Foster Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Around 670,000 children in the U.S will spend time in foster care in any given year,
2 and the number of children in foster care has been increasing since 2012¹⁻⁴; and
3

4 Whereas, Children in foster care are one of the most vulnerable populations, often suffering
5 from a higher likelihood of early adverse childhood experiences and disproportionately affected
6 by lack of appropriate housing, behavioral problems, and the disparities associated with minority
7 populations^{2,8-10};
8

9 Whereas, A series of highly-publicized episodes of abuse, neglect, and child deaths in the for-
10 profit foster care system prompted the Senate Finance Committee to conduct an investigation
11 into the privatization of foster care services, and the Committee published a report of their
12 findings in 2017^{3,5,6}; and
13

14 Whereas, The Senate Finance Committee report found that children in the foster care system
15 die at an alarmingly high rate that is 42% higher than the national death rate for children with
16 similar health conditions and risk factors, and 70% of these deaths were unexpected^{3,7}; and
17

18 Whereas, These deaths were often found to have occurred in cases in which children had been
19 placed with foster parents who had a record of abuse;^{3,5} and
20

21 Whereas, In some cases children were placed in homes with individuals convicted of kidnapping
22 and other serious crimes, with individuals who had substance abuse problems, and in the care
23 of caretakers who had previously failed foster care placements;^{3,5,6,7} and
24

25 Whereas, Investigations were conducted in only 15% of deaths with no subsequent action or
26 autopsy performed in all other deaths^{3,7}; and
27

28 Whereas, The report found that policies and procedures meant to monitor child welfare and
29 providers' performance and outcomes were not consistently followed³; and
30

31 Whereas, AMA policy H-515.960 exhorts "physicians [to] act as advocates for children, and as
32 such, have a responsibility legally and otherwise, to protect children when there is a suspicion of
33 abuse"; therefore be it
34

35 RESOLVED, That our American Medical Association support legislation requiring investigations
36 into the deaths of children in the foster care system that occur while the child is in the foster
37 care system. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.
Received: 05/09/19

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RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Citation: Res. 907, I-17

Identifying and Reporting Suspected Child Abuse H-515.960

1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

Citation: CSAPH Rep. 2, I-09; Appended: Res. 411, A-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress

and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

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

Importance of Autopsies H-85.954

1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.
2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.
3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program, and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.
4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.
5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.
6. Our AMA calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies.
7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.
8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.

Citation: (CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(A-19)

Introduced by: Medical Student Section

Subject: Opposition to Requirements for Gender-Based Medical Treatments for Athletes

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Differences of Sex Development (DSD), also known as intersex, are defined as
2 congenital conditions in which development of chromosomal, gonadal, or anatomic sex is
3 atypical¹; and
4

5 Whereas, The estimated incidence of DSD ranges from 1 in 5,000 ambiguous genitalia to 1 in
6 1,500 for atypical genitalia^{2,3,4}; and
7

8 Whereas, A 2014 study supported by the International Association of Athletics Federations
9 (IAAF) and the World Anti-Doping Agency found that 5 of 839 elite female athletes were
10 diagnosed with hyperandrogenic 46 XY differences of sex development after medical
11 examination⁵; and
12

13 Whereas, In 2011, the Women's Sports Foundation (WSF) released a position statement
14 arguing that testing female athletes' testosterone levels would be "problematic and ill-advised,"
15 noting that widely-varying natural levels of testosterone in male athletes are not subject to the
16 same scrutiny⁶; and
17

18 Whereas, The same WSF position statement also argued that it would be inappropriate to single
19 out female athletes with naturally higher testosterone levels for exclusion from competition while
20 other competitive advantages such as height, access to coaching from a young age, or
21 upbringing in a high altitude are not restricted⁶; and
22

23 Whereas, In April 2018, the IAAF imposed new regulations that require female athletes to
24 maintain their blood testosterone levels below five nmol/L to compete in Restricted Events in
25 International Competitions^{7,8}; and
26

27 Whereas, The IAAF regulations were based on a study commissioned by the IAAF published in
28 the *British Journal of Sports Medicine* to investigate evidence of elevated testosterone levels
29 and improved athletic performance⁹; and
30

31 Whereas, Independent researchers analyzed the data used for the IAAF study and found that
32 the performance data used in the study's analysis was either anomalous or inaccurate 17% to
33 33% of the time, calling into question the study itself, with some experts calling for retraction^{10,11};
34 and
35

36 Whereas, These new regulations have led the IAAF to request that female athletes with
37 naturally high testosterone levels undergo medically unnecessary interventions to lower their
38 testosterone levels to be allowed to participate in competitions, a request that is opposed by

1 many including the Human Rights Watch, the Sport and Recreation Minister of South Africa, the
2 Canadian Centre for Ethics in Sport, the Canadian Association for the Advancement of Women
3 in Sport and Physical Activity^{12,13,14,15,16}; and
4

5 Whereas, More than 200 genetic polymorphisms have been associated with improved athletic
6 performance, yet none of these variations lead to the disqualification of athletes^{17,18}; and
7

8 Whereas, There is no upper limit for testosterone levels imposed on male athletes, and those
9 with male hypogonadism can apply for an exemption to take steroids to increase testosterone
10 levels, compared to female athletes with hyperandrogenism who can be disqualified unless they
11 pursue medical treatments or surgery to lower these levels¹⁹; and
12

13 Whereas, The AMA has previously taken stances opposing medically unnecessary services
14 (H-470.978, H-525.987); therefore be it
15

16 RESOLVED, That our American Medical Association oppose any regulations requiring
17 mandatory medical treatment or surgery for athletes with Differences of Sex Development
18 (DSD) to be allowed to compete in alignment with their identity (Directive to Take Action); and
19 be it further
20

21 RESOLVED, That our AMA oppose the creation of distinct hormonal guidelines to determine
22 gender classification for athletic competitions. (Directive to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Blood Doping H-470.978

The AMA believes that a physician who participates in blood doping is deviating from his professional responsibility and that blood doping must be considered in the category of unnecessary medical services. Citation: (CEJA Rep B, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Surgical Modification of Female Genitalia H-525.987

Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia.

Citation: (Res. 13, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11

Non-Therapeutic Use of Pharmacological Agents by Athletes H-470.994

Our AMA: (1) opposes the use of drugs for the purpose of enhancing athletic performance or sustaining athletic achievement. This action in no way should be construed as limiting a physician's proper use of drugs in indicated treatment of athletic injuries or clinical symptoms of individual athletes; and (2) endorses efforts by state level high school athletic associations to establish programs which include enforceable guidelines concerning weight and body fat changes on a precompetition basis for those sports in which weight management is a concern.

Citation: (Res. 89 part 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Modified by Res. 401, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

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.

Citation: (Res. 4, A-13; Appended: BOT Rep. 26, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(A-19)

Introduced by: New Mexico

Subject: Request to the AMA Council on Ethical and Judicial Affairs (CEJA) to Consider Specific Changes to the Code of Medical Ethics Opinion E-5.7, “Physician-Assisted Suicide”, in Order to Remove Inherent Conflicts Within the Code, to Delete Pejorative, Stigmatizing Language, and to Adopt an Ethical Position of Engaged Neutrality

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Our American Medical Association House of Delegates at the 2018 Interim Meeting
2 rejected the recommendation in CEJA Report 2-I-18 that the Code of Medical Ethics Opinion
3 E-5.7 “Physician-Assisted Suicide” (PAS) not be amended, and therefore did not adopt CEJA
4 Report 2-I-18; and

5
6 Whereas,

- 7 • The Code of Medical Ethics Opinion E-5.7 1 states, ‘Physician-assisted suicide is
8 fundamentally incompatible with the physician’s role as healer, would be difficult or
9 impossible to control, and would pose serious societal risks” – a characterization that
10 clearly expresses the opinion that PAS is unethical; yet,
- 11 • The Code of Medical Ethics Opinion E-1.1.7 2 “Physician Exercise of Conscience” creates
12 the clear understanding, not disputed by CEJA, that physicians participating in PAS are
13 acting based on a thoughtful moral basis that is not outside the boundaries of ethical
14 behavior; thereby,
- 15 • Creating an inherent contradiction within the Code of Medical Ethics: that physicians may
16 ethically participate in something that is described as unethical; and

17
18 Whereas, It is important to recognize that ethical physicians can disagree, but that all
19 perspectives be respected and none disparaged; and

20
21 Whereas, In addition to the inherent contradiction noted above, the decision that “the Code of
22 Medical Ethics not be amended” is not consistent with the tenor of CEJA Report 2, and does not
23 adequately address concerns about the implications of existing language in Opinion E-5.7; and

24
25 Whereas, The terms that stakeholders use to refer to the practice of physicians prescribing
26 lethal medication to be self-administered by terminally ill patients reflect differing ethical
27 perspectives, for the purposes of this resolution where existing language is not being cited, we
28 have chosen to use “Physician-Assisted Dying” (PAD) as adopted by the American Academy of
29 Hospice and Palliative Medicine³ as being much more consistent with the goal of being
30 respectful and non-disparaging; and

31
32 Whereas, CEJA Report 2 cites a specific example of irreconcilable differences in principled core
33 beliefs, but neglects to note that CEJA in that instance had very wisely adopted a non-
34 judgmental and non-stigmatizing approach that has served the profession well; and

1 Whereas, PAD is a decision made by a competent adult about how, when, where and with
2 whom to end life in the face of an irreversible terminal illness where continued living is not an
3 option, and therefore is not equivalent to or appropriately described as “suicide”, which can be
4 most accurately defined as a decision by a person to take his or her own life rather than to
5 continue living; and
6

7 Whereas, The American Association of Suicidology, in a treatise cited by CEJA¹², clearly states
8 that, “Suicide and physician aid in dying are conceptually, medically, and legally different
9 phenomena... the term ‘physician-assisted suicide’ in itself constitutes a critical reason why
10 these distinct death categories are so often conflated, and should be deleted from use.”; and
11

12 Whereas, Eight states and a federal district currently authorize PAD as an end-of-life option,
13 making PAD available to 21% of Americans, and sixteen additional states have introduced
14 legislation to enact it; and
15

16 Whereas, As determined by numerous polls and surveys, the overwhelming majority of the
17 public, consistently over 70% ⁴, supports PAD; and
18

19 Whereas, National surveys^{5,6,7,8,11} of physicians demonstrate increasing support for PAD (from
20 46% in 2010 to 57% in 2016) and decreasing opposition to PAD (from 41% in 2010 to 29% in
21 2016); and
22

23 Whereas, Surveys of physicians conducted by the Colorado Medical Society ⁶, the Maryland
24 State Medical Society ⁷, and the Massachusetts Medical Society⁸ found majorities in support of
25 PAD (56%, 54%, and 60% respectively); and
26

27 Whereas, There is no empirical evidence to substantiate the current description of PAD in
28 Opinion E-5.7 as a form of abandonment “of a patient once it is determined that cure is
29 impossible”, and in fact CEJA acknowledges that PAD is also considered to be “an expression
30 of care and compassion”; and
31

32 Whereas, Claims in the Code of Medical Ethics Opinion 5-7 that characterize PAD as “difficult or
33 impossible to control”, causing “more harm than good,” and posing “serious societal risks”, are
34 unsubstantiated and speculative based on data reviews ⁹ cited in CEJA Report-2 that find
35 conflicting interpretations but no definitive evidence to justify concerns for potential abuse; and
36

37 Whereas, It is widely acknowledged by patients, physicians and ethicists that suffering is not
38 limited to physical pain, but equally includes emotional suffering due to loss of autonomy, and a
39 loss of control over one’s destiny while an opportunity for such control clearly exists, as
40 evidenced by overwhelming attestations on the part of patients who have chosen the option of
41 PAD as having a sense of enormous relief and comfort, even by patients who in the end never
42 take the cocktail they’ve been prescribed; and
43

44 Whereas, “Engaged Neutrality”¹⁰ is a position that is neither “pro” nor “con”, but allows for the
45 expression of diverse views while ensuring safeguards and appropriate standards, educating
46 the public, care givers and physicians, and protecting physicians’ freedom to participate in or opt
47 out of PAD according to their own personal values; therefore be it

1 RESOLVED, That our American Medical Association Council on Judicial and Ethical Affairs be
2 strongly encouraged to remove from the Code of Medical Ethics Opinion E-5.7 “Physician-
3 Assisted Suicide” judgmental, stigmatizing language that is not evidence based, is at odds with
4 the conclusions of CEJA Report 2 in recognizing shared values of care, compassion, respect
5 and dignity, and creates an ethical conflict with the Code of Medical Ethics Opinion E-1.1.7
6 “Physician Exercise of Conscience”; specifically by:

- 7
- 8 (a) Deleting all references to “suicide”, including “Physician-assisted suicide” and replacing
9 such language by referring to “Physician-assisted dying (PAD)”;
 - 10 (b) Deleting language that suggests that PAD is a form of doing harm and is therefore
11 antithetical to the admonition to “do no harm”, such as “assisted suicide would ultimately
12 cause more harm than good”;
 - 13 (c) Deleting language that characterizes PAD as a choice by a patient “that death is preferable
14 to life” and replacing that language with a description of PAD as giving a terminally ill patient
15 the option of being in control of the manner of his or her death, without assigning a value
16 judgment to that option;
 - 17 (d) Deleting language that characterizes PAD as “fundamentally incompatible with the
18 physician’s role as healer”, and instead recognizing that a physician who participates in PAD
19 is doing so as an act of compassion and caring for patients who have no prospect of healing
20 their fatal illness;
 - 21 (e) Delete language that suggests that PAD is not compatible with “responding to the needs of
22 patients at the end of life” or that PAD is “abandonment” (Directive to Take Action); and be it
23 further
- 24

25 RESOLVED, In recognition of the fact that highly ethical physicians may have differing opinions
26 on Physician Assisted Dying (PAD), but also in recognition of our respect for patient autonomy
27 and the growing numbers of patients who wish to exercise choice over the manner of imminent
28 death, that our American Medical Association’s Council on Judicial and Ethical Affairs (CEJA)
29 be strongly encouraged to modify Code of Medical Ethics Opinion E-5.7 “Physicians-Assisted
30 Suicide” to follow the lead of a number of state and national medical societies by adopting the
31 ethical position of “Engaged Neutrality”, defined as neither in favor of nor or in opposition to
32 PAD, while providing reassurance that our AMA will be a resource to lawmakers, physicians and
33 the public to ensure compliance with standards of lawful medical practice, and to protect
34 physicians’ freedom to participate or not participate in PAD in accordance with their personal
35 beliefs and our AMA’s Opinion E-1.1.7 “Physician Exercise of Conscience”. (Directive to Take
36 Action)

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

Received: 05/09/19

¹ AMA Code of Medical Ethics, Opinion E-5.7, Physician-Assisted Suicide, <https://tinyurl.com/y27hy743>

² AMA Code of Medical Ethics, Opinion E-1.1.7, Physician Exercise of Conscience, <https://tinyurl.com/y4odsvmf>

³ Statement on Physician-Assisted Dying, AAHPM Board of Directors, Jun 24, 2016 <https://tinyurl.com/y3e4fka7>

⁴ 72% of Americans Support Medical Aid in Dying, Gallup Poll May 31, 2018 <https://tinyurl.com/ycaon4zw>

⁵ Medscape Ethics Report 2016: Life, Death, and Pain, Dec 23, 2016 <https://tinyurl.com/y3u63b8c>

⁶ Colorado Medical Society Member Survey, On Issues Surrounding Physician-Assisted Death, Feb 2016
<https://tinyurl.com/y54b947y>

⁷ MedChi Survey on Physician Assisted Suicide/Aid in Dying, June-July 2016 <https://tinyurl.com/y5dl4plg>

⁸ Massachusetts Medical Society (MMS) Survey on Medical Aid in Dying, August 2017 <https://tinyurl.com/y34wqrrz>

⁹ Battin MP, van der Heide A, Ganzini L, et al. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups, Journal of Medical Ethics 2007;33:591-597 <https://tinyurl.com/yxharp6k>

¹⁰ Frye J, Youngner SJ. A Call for a Patient-Centered Response to Legalized Assisted Dying, Ann Intern Med. 2016;165:733–734. doi: 10.7326/M16-1319 <https://tinyurl.com/yyzqmexo>

¹¹ Assisted Death: Physician Support Continues to Grow, Medscape, Dec 2016 <https://tinyurl.com/y3a6k2bl>

¹² Statement of the American Association of Suicidology, Oct 2017: Suicide is not the same as “Physician Aid in Dying”
<https://tinyurl.com/yxholm6f>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Health, In All Its Dimensions, Is A Basic Human Right

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas In 1946, the World Health Organization (WHO) declared that the “enjoyment of the
2 highest attainable standard of health is one of the fundamental rights of every human being.”¹
3 Health is defined by the WHO as “a state of complete physical, mental and social well-being and
4 not merely the absence of disease or infirmity.”² The constitution added that governments have
5 a responsibility for the health of their peoples which can be fulfilled only by the provision of
6 adequate health and social measures”³ The international community furthered the right to health
7 movement in the 1948 United Nations Declaration of Human Rights.⁴; and

8
9 Whereas, Presently, the United States is one of the only industrialized nations that doesn’t
10 provide universal access to health care;⁵ and

11
12 Whereas, United States citizens have a longstanding pattern of poorer health, and are dying at
13 younger ages than people in almost all other “peer” countries, including other high-income
14 democracies in western Europe, as well as Canada, Australia, and Japan;⁶ and

15
16 Whereas, The United States guarantees all citizens an education, access to fire and police
17 services, a national postal service, protection by the military, a national park system, and many
18 other federal- and state-funded services, but the country has not yet committed to ensuring that
19 all of its citizens have health care in its many dimensions;⁷ and

20
21 Whereas, Social determinants of health (the conditions in which people are born, grow, live,
22 learn, work, and age that affect a wide range of health and quality-of-life outcomes and risks)
23 are widely recognized as a primary approach to reducing health disparities and have become a
24 public health focus at the global, national, state, and local levels;^{8,9,10} and

25
26 Whereas, Numerous studies in recent decades have demonstrated the significant role
27 nonmedical factors play in physical and mental health;¹¹and

¹ World Health Organization. Preamble to the Constitution of the World Health Organization. In: *Proceedings and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946*. New York, NY: World Health Organization; 1948:100. *Official Records of the World Health Organization*;

² Id.

³ Constitution of the World Health Organization. https://www.who.int/governance/eb/who_constitution_en.pdf

⁴ United Nations. The Universal Declaration of Human Rights. <http://www.un.org/en/documents/udhr/>

⁵ Bauchner H. Health Care in the United States: A Right or a Privilege. *JAMA*. 2017;317(1):29. doi:10.1001/jama.2016.19687

⁶ National Research Council (US); Institute of Medicine (US); Woolf SH, Aron L, editors. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington (DC): National Academies Press (US); 2013. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK115854/> doi: 10.17226/13497

⁷ *JAMA*. 2017;317(1):29. doi:10.1001/jama.2016.19687

⁸ <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#c>.

⁹ http://www.who.int/social_determinants/thecommission/en/.

¹⁰ <https://www.cdc.gov/socialdeterminants/>.

¹¹ <http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american>.

1 Whereas, Food insecurity, for example, is associated with increased risk for diseases and
2 conditions like diabetes, hypertension, and depression in adults, and with increased risk for
3 impaired brain development, hospitalizations, iron-deficiency anemia, mental health, and
4 behavioral disorders in children;^{12,13,14,15,16} and
5

6 Whereas, Housing insecurity and homelessness are related to poorer physical health, including
7 higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS and higher rates of
8 medical hospitalizations; and
9

10 Whereas, Blue Cross Blue Shield of Massachusetts Foundation noted that there is strong
11 evidence that increased investment in selected social services as well as various models of
12 partnership between health care and social services can confer substantial health benefits and
13 reduce health care costs for targeted populations;¹⁷ and
14

15 Whereas, The social determinants of health play a key role in health outcomes and health
16 disparities, and that addressing the social determinants of health for patients and communities
17 is critical to the health of our patients, our communities, and a sustainable, effective health care
18 system; and
19

20 Whereas, Planning the most effective strategy(s) to provide health care coverage in the United
21 States is an evolving process, and will require careful evaluation, assessment, and modification;
22 and
23

24 Whereas, The core principles to guide the envisioned future reforms and goals of health care
25 have not been clearly stated; and
26

27 Whereas, Strategies to address future health care reforms and goals cannot be accomplished
28 without stating and acknowledging the principles that will serve as the compass by which
29 decisions will be made; and
30

31 Whereas, Physicians and medical societies should help define the principles upon which health
32 care reforms and goals are structured and speak with a single voice and acknowledge that
33 health is a basic right for every person in a just society, and not a privilege to be available and
34 affordable only for a majority; and
35

36 Whereas, Physician members of the AMA rightfully focus on the provision of health care and its
37 role in providing for the health of populations and a right to health care is only one aspect of a
38 larger right to health;¹⁸ and

¹² Hunger and Health: The Impact of **Poverty**, Food Insecurity, and Poor Nutrition on Health and Well-Being. Food Research and Action Center (FRAC). 2017.

¹³ Hunger and Health: The Role of the Federal Child Nutrition Programs in Improving Health and Well-Being. Food Research and Action Center (FRAC). 2017.

¹⁴ Olsen CM. Nutrition and Health Outcomes Associated with Food Insecurity and Hunger. *Journal of Nutrition*. 1999;129(2):5215-5245.

¹⁵ Cook JT, Frank DA, Berkowitz C, Black MM, Casey PH, Cutts DB, et al. Food Insecurity is Associated with Adverse Health Outcomes among Human Infants and Toddlers. *Journal of Nutrition*. 2004;134(6):1432-1438.

¹⁶ Gunderson C, Ziliak JP. Food insecurity and health outcomes. *Health Affairs*. 2015;34(11):1830

¹⁷ https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_ExecSumm_final.pdf.

¹⁸ World Health Organization. Preamble to the Constitution of the World Health

1 Whereas, In addition to health care, a right to health encompasses a right to provision of social
2 measures including sufficient food and drinking water, adequate housing and working
3 conditions, satisfactory education; ¹⁹and
4

5 Whereas, Spending on social measures arguably has a greater aggregate impact on population
6 health than medical care; ²⁰ and
7

8 Whereas, The United States currently gives limited attention to social programs and continues
9 to outspend its peers on medical care;²¹ and
10

11 Whereas, We as physicians share the professional responsibility to advocate for the health and
12 well-being of our patients; and
13

14 Whereas, We as the AMA have consistently affirmed our common belief that comprehensive
15 health care access should be available to all; and
16

17 Whereas, Principles to direct our AMA advocacy for patients should support a right to health, in
18 all its dimensions (including addressing social determinants of health and universal access to
19 timely, acceptable and affordable health care of appropriate quality care); and
20

21 Whereas, AMA policies on access to healthcare and its ongoing work and focus on social
22 determinants of health and preventive care would benefit from core principles that support future
23 advocacy and education; therefore be it
24

25 RESOLVED, That our American Medical Association acknowledge that enjoyment of the
26 highest attainable standard of health, in all its dimensions, including health care is a basic
27 human right (New HOD Policy); and be it further
28

29 RESOLVED, That the provision of health care services as well as optimizing the social
30 determinants of health is an ethical obligation of a civil society. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/09/19

¹⁹ United Nations. The Universal Declaration of Human Rights.

²⁰ K. Davis, K. Stremikis, C. Schoen, and D. Squires, Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014.

<https://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror-wall-2014-update-how-us-health-care-system>

²¹ Bradley EH, Elkins BR, Herrin J, Elbel B. Health and social service expenditures: associations with health outcomes. *BMJ Qual Saf.* 2011;20(10):826-831.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject: Opposition to Involuntary Civil Commitment for Substance Use Disorder
Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

1 Whereas, Involuntary civil commitment is defined by law as the commitment of a person who is
2 ill, incompetent, drug-addicted, or the like, without the consent of the person being committed;
3 and
4
5 Whereas, In response to the opioid crisis, the scope of these laws has rapidly expanded, as the
6 number of states with such laws went from 18 in 1991 to 38 jurisdictions in 2016¹; and
7
8 Whereas, Existing data on both the short- and long-term outcomes following involuntary civil
9 commitment for reasons related to substance-use disorder does not support its broad
10 utilization²; and
11
12 Whereas, Data suggests that coercive treatment puts patients at higher risk of fatal overdose³;
13 and
14
15 Whereas, The legal standards and procedures for involuntary civil commitment are very broad
16 and allow for the presiding judge to overrule the clinical determination of the commitment's
17 appropriateness; and
18
19 Whereas, Involuntary civil commitment of persons for reasons related to substance-use disorder
20 has already been implicated in human rights abuses and suicides⁴; and
21
22 Whereas, Overdose data has shown that people who were involuntarily committed were more
23 than twice as likely to experience a fatal overdose as those who completed voluntary treatment⁵;
24 and
25
26 Whereas, Our AMA urges the formulation of a comprehensive national policy on drug abuse
27 that should expand the availability and reduce the cost of treatment programs for substance use
28 disorders, including addiction (H-95.981, "Federal Drug Policy in the United States"); and
29
30 Whereas, Our AMA urges expanding the quantity and improving the quality of drug treatment
31 programs (H-95.973, "Increased Funding for Drug Treatment"); and
32
33 Whereas, Our AMA policy is that health promotion should be a collaborative, patient-centered
34 process that promotes trust and recognizes patients self-directed roles and responsibilities in
35 maintaining health (Code of Medical Ethics Opinion 8.11 Health Promotion and Preventive
36 Care)⁶; therefore be it

1 RESOLVED, That our American Medical Association oppose involuntary civil commitment
2 without judicial involvement of persons for reasons solely related to substance-use disorder
3 (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA work to advance policy and programmatic efforts to address gaps in
6 voluntary substance-use treatment services. (Directive to Take Action)

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

Received: 05/09/19

¹Involuntary Commitment For Individuals With A Substance Use Disorder Or Alcoholism, The National Alliance For Model State Drug Laws, 100 ½ E. Main Street, Manchester, Iowa 52057, © 2016 Research is current as of August 2016. Web/PDF <http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf>

²Nature and Utilization of Civil Commitment for Substance Abuse in the United States, *J Am Acad Psychiatry Law* 43:313–20, 2015 Web <http://jaapl.org/content/43/3/313.long> PDF <http://jaapl.org/content/jaapl/43/3/313.full.pdf>

³An Assessment of Opioid Related Deaths in Massachusetts (2013-2014) <https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf>

⁴Patients call Plymouth addiction center a mere jail - [The Boston Globe](#)

⁵<https://www.mass.gov/service-details/chapter-55-overdose-report>

⁶<https://www.ama-assn.org/delivering-care/ethics/health-promotion-and-preventive-care>