

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 02 New Specialty Organizations Representation in the House of Delegates
- 26 Research Handling of De-Identified Patient Information

CC&B Report(s)

- 01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing

CEJA Report(s)

- 01 Competence, Self-Assessment and Self-Awareness
- 02 Physician Assisted Suicide
- 03 CEJA's Sunset Review of 2009 House Policies

Resolution(s)

- 001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
- 002 Addressing Existential Suffering in End-of-Life Care
- 003 Conforming Sex and Gender Designation on Government IDs and Other Documents
- 004 Reimbursement for Care of Practice Partner Relatives
- 005 Right for Gamete Preservation Therapies
- 006 Use of Person-Centered Language
- 007 Delegation of Informed Consent

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 11 BACKGROUND

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*

8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
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

REFERENCES

1. U.S. Department of Health and Human Services and National Institutes of Health. *Clinical Research and the HIPAA Privacy Rule*. 2004 06/22/04 [cited 2018 August 24]; Available from: https://privacyruleandresearch.nih.gov/clin_research.asp.
2. Rothstein, M.A., *Is Deidentification Sufficient to Protect Health Privacy in Research?* The American journal of bioethics : AJOB, 2010. 10(9): p. 3-11.
3. United States, *The Health Insurance Portability and Accountability Act of 1996*. 1996, U.S. Department of Labor Employee Benefits Security Administration: Washington, D.C.
4. U.S. Department of Health and Human Services. *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the HIPAA Privacy Rule*. 2015 11/06/15 [cited 2018 August 24]; Available from: <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>.
5. U.S. Department of Health and Human Services, *Summary of the HIPAA Privacy Rule*. 2013.
6. Rothstein, M.A., *Currents in contemporary bioethics. Access to sensitive information in segmented electronic health records*. J Law Med Ethics, 2012. 40(2): p. 394-400.
7. Gammon, A. and D.W. Neklason, *Confidentiality & the Risk of Genetic Discrimination: What Surgeons Need to Know*. Surgical oncology clinics of North America, 2015. 24(4): p. 667-681.
8. U.S. Department of Health and Human Services, *HIPAA FAQs: May a health information organization (HIO), acting as a business associate of a HIPAA covered entity, de-identify information and then use it for its own purposes?* 2008.
9. Klein, D. *Comparing the California Consumer Privacy Act (CCPA) and the EU's General Data Protection Regulation (GDPR)* 2018.
10. State of California, *California Consumer Privacy Act of 2018*, in 1.81.5. 2018.
11. Mathews, K. and C. Bowman, *The California Consumer Privacy Act of 2018*, in *Proskauer Privacy Law Blog*, Kristen J. Mathews, Editor. 2018: California.
12. Orion Health, *Introduction to Machine Learning in Healthcare*. 2016, Orion Health.
13. Fatima Paruk, *How to increase adoption of machine learning in healthcare*, in *Vital Signs Blog*. 2018, Modern Healthcare.
14. Orion Health, *Orion Health Unveils New Predictive Intelligence Using Machine Learning to Help Save Billions in Healthcare Costs*. 2018, PRNewswire.
15. NCVHS Ad Hoc Workgroup for Secondary Uses of Health Data, *HIPAA Privacy Rule and Secondary Uses of Health Information*. 2007, United States Department of Health and Human Services.
16. U.S. Department of Health and Human Services, *Code of Federal Regulations Title 45 Public Welfare Part 46 Protection of Human Subjects*, in 45. 2009.
17. Federal Trade Commission, *Protecting Consumer Privacy in an Era of Rapid Change*. 2012.
18. Harvard University, *Harvard Research Data Security Policy*, Office of the Vice Provost for Research, Editor. 2014.
19. Federal Register, *Federal Policy for the Protection of Human Subjects*. Vol. 82, No. 12. January 19, 2017. Available from: <https://www.govinfo.gov/content/pkg/FR-2017-01-19/pdf/2017-01058.pdf>
20. Benitez, K. and B. Malin, *Evaluating re-identification risks with respect to the HIPAA privacy rule*. J Am Med Inform Assoc, 2010. 17(2): p. 169-77.
21. Sweeney, L., A. Abu, and J. Winn, *Identifying Participants in the Personal Genome Project by Name (A Re-identification Experiment)*. 2013.
22. Sweeney, L., *Weaving Technology and Policy Together to Maintain Confidentiality*. J Law Med Ethics, 1997. 25(2-3): p. 98-110.
23. Na, L., et al., *Feasibility of reidentifying individuals in large national physical activity data sets from which protected health information has been removed with use of machine learning*. JAMA Network Open, 2018. 1(8): p. e186040.

24. Gymrek, M., et al., *Identifying personal genomes by surname inference*. *Science*, 2013. 339(6117): p. 321-4.
25. El Emam, K., et al., *A Systematic Review of Re-Identification Attacks on Health Data*. *PLoS ONE*, 2011. 6(12): p. e28071.
26. Sakowitz-Klein, J., *Proposed ACO Rule Implicates HIPAA*, in *Health Reform Resource Center*. 2011, Akin Gump Strauss Hauer & Feld, LLP.
27. U.S. Department of Health and Human Services, *HIPAA FAQs: What is the difference between "consent" and "authorization" under the HIPAA Privacy Rule?* 2013.
28. 23andMe.com. *Privacy Policy*. 2018 July 17, 2018 September 17, 2018; Available from: <https://www.23andme.com/about/privacy/>.
29. Advisory Board *Memorial Sloan Kettering insiders face controversy over AI startup*. 2018.
30. Office of the National Coordinator for Health Information Technology, *Guide to Privacy and Security of Electronic Health Information*. 2015, U.S. Department of Health and Human Services.
31. American Academy of Family Physicians. *Data Stewardship*. 2014 [cited 2018 October 3]; Available from: <https://www.aafp.org/about/policies/all/data.html>.
32. American College of Physicians, *Policy Compendium*, D.o.G.A.a.P. Policy, Editor. 2016: Washington, DC.

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 recredited as
28 the delegate in accordance with Bylaw 2.10.4. An alternate delegate who has been
29 properly recredited 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.

REFERENCES

1. *American Medical Association Code of Medical Ethics*. Principle I. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
2. *American Medical Association Code of Medical Ethics*. Opinion 11.2.1, Professionalism in health care systems. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
3. *American Medical Association Code of Medical Ethics*. Opinion 1.2.3, Consultation, referral and second opinions. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
4. *American Medical Association Code of Medical Ethics*. Opinion 1.1.6, Quality. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
5. Gordon MJ. A review of the validity and accuracy of self-assessments in health professions training. *Acad Med*. 1991;66:762–769.
6. *American Medical Association Code of Medical Ethics*. Principle II. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
7. *American Medical Association Code of Medical Ethics*. Opinion 9.4.2, Reporting incompetent or unethical behavior by colleagues. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
8. *American Medical Association Code of Medical Ethics*. Opinion 9.4.3, Discipline and medicine. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
9. *American Medical Association Code of Medical Ethics*. Opinion 8.6, Promoting patient safety. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
10. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226–235.
11. Epstein RM, Siegel DJ, Silberman J. Self-monitoring in clinical practice: a challenge for medical educators. *J Contin Educ Health Professions*. 2008;28(1):5–13.
12. Colthart I, Bagnall G, Evans A, et al. The effectiveness of self-assessment on the identification of learner needs, learner activity, and impact on clinical practice: BEME Guide no. 10. *Medical Teacher*. 2008;30:124–145.
13. DA, Mazmanian PE, Fordis M, et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA*. 2006;296:1094–1102.
14. Whitehouse A, Hassell A, Bullock A, et al. 360 degree assessment (multisource feedback) of UK trainee doctors: field testing of team assessment behaviors (TAB). *Medical Teacher*. 2007;29:171–178.
15. O’Sullivan P, Greene C. Portfolios: possibilities for addressing emergency medicine resident competencies. *Acad Emerg Med*. 2002;9(11):1305–1309.
16. Leigh IW, Smith IL, Bebeau M, et al. Competency assessment models. *Professional Psychology: Research and Practice*. 2007;38(5):463–473.
17. Lipsett PA, Harris I, Downing S. Resident self-other assessor agreement: influence of assessor, competency, and performance level. *Arch Surg*. 2011;146(8):901–906.
18. Svirko E, Lambert T, Goldacre MJ. Gender, ethnicity and graduate status, and junior doctors’ self-reported preparedness for clinical practice: national questionnaire surveys. *J Royal Society Med*. 2014;107(2):66–74.
19. Dunning D. Strangers to ourselves? *The Psychologist*. 2006;19(10):600–603.

20. Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: how the desire for feedback and reticence to collect and use it can conflict. *Acad Med*. 2011;86(9):1120–1127.
21. Sargeant J, Mann K, Ferrier S. Exploring family physicians' reactions to multisource feedback: perceptions of credibility and usefulness. *Medical Education*. 2005;39:497–504.
22. Jackson JL, Kay C, Jackson WC, Frank M. The quality of written feedback by attendings of internal medicine residents. *J Gen Intern Med*. 2015;30(7):973–978.
23. Sargeant J, Amson H, Chesluk B, et al. The processes and dimensions of informed self-assessment: a conceptual model. *Acad Med*. 2010;85:1212–1220.
24. Moulton CE, Regehr G, Mylopoulos M, MacRae HM. Slowing down when you should: a new model of expert judgment. *Acad Med*. 2007;82(10 Suppl):S109–S116.
25. Moulton C, Regehr G, Lingard L, et al. Slowing down to stay out of trouble in the operating room: remaining attentive in automaticity. *Acad Med*. 2010;85(10):1571–1577.
26. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. *Acad Emerg Med*. 2002;9(11):1184–1204.
27. Sklar DP. How do we think? can we learn to think? *Acad Med*. 2014;89:191–193.
28. Klein JG. Five pitfalls in decisions about diagnosis and prescribing. *BMJ* 2005;330:781–784.
29. Croskerry P, Petrie DA, Reilly B, Tait G. Deciding about fast and slow decisions. *Acad Med*. 2014;89:197–200.
30. Kadar N. Peer review of medical practices: missed opportunities to learn. *AJOG*. 2014; Dec:596–601.
31. Cooper LA, Roter DL, Carson KA, et al. The association of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health*. 2012;102:979–987.
32. Eva KW, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. *Acad Med*. 2005;80(10 Suppl):S46–S54.
33. Eva KW, Regehr G. Knowing when to look it up: a new conception of self-assessment ability. *Acad Med*. 2007;82(10 Suppl): 581–584.
34. Rivera AJ, Karsh B-T. Interruptions and distractions in healthcare: review and reappraisal. *Qual Saf Health Care*. 2010;19(4):304–312.
35. Grundgeiger T, Sanderson P. Interruptions in health care: theoretical views. *Intl J Med Informatics*. 2009;78:293–307.
36. Monsell S. Task switching. *TRENDS in Cog Sciences*. 2003;7(3).
37. Relihan E, O'Brien V, O'Hara S, et al. The impact of a set of interventions to reduce interruptions and distractions to nurses during medication administration. *Qual Saf Health Care*. 2010; May 28.
38. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv in Health Sci Educ*. 2009;14:595–621.
39. Epstein RM. Mindful practice. *JAMA*. 1999;282(9):833–839.

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.

REFERENCES

1. Council on Ethical and Judicial Affairs. Decisions near the end of life. *JAMA* 1992;267:2229–2233.
2. Vamos MJ. Physician-assisted suicide: saying what we mean and meaning what we say. *ANZJP* 2012;46:84–86.
3. Herx L. Physician-assisted death is not palliative care. *Curr Oncol* 2015;22:82–83.
4. American Association of Suicidology. “Suicide” Is Not the Same as “Physician Aid in Dying”. November 12, 2017. Available at <http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf>. Accessed July 10, 2018.
5. Quill TE, Back AL, Block SD. Responding to patients requesting physician-assisted death: physician involvement at the very end of life. *JAMA* 2016;315:245–246.
6. American Academy of Hospice and Palliative Medicine. *Statement on Physician-Assisted Dying*, June 24, 2016. Available at <http://aahpm.org/positions/pad>. Accessed February 3, 2017.
7. Quill TE, Cassel CK. Professional organizations’ position statements on physician-assisted suicide: a case for studied neutrality. *Ann Intern Med* 2003;138:208–211.
8. Sulmasy DP, Finlay I, Fitzgerald F, et al. Physician-assisted suicide: why neutrality by organized medicine is neither neutral nor appropriate. *J Gen Intern Med*. 2018;33(8):1394–1399.
9. Johnstone M-J. Organization position statements and the stance of “studied neutrality” on euthanasia in palliative care. *J Pain Symptom Manage* 2012;44:896–907.
10. Crigger BJ, McCormick PW, Brotherton SL, Blake V. Report by the American Medical Association’s Council on Ethical and Judicial Affairs on physicians’ exercise of conscience. *J Clin Ethics* 2016;27:291–226.
11. Chochinov HM. Physician-assisted death in Canada. *JAMA* 2016;315:253–254.
12. Battin MP, van der Heide A, Ganzini L, van der Wal G, Onwuteaka-Philipsen B. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups. *J Med Ethics* 2007;33:591–597.
13. Finlay IG, George R. Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon’s data. *J Med Ethics* 2010;37:171–174.
14. Golden M, Zoanni T. Killing us softly: the dangers of legalizing assisted suicide. *Disability and Health Journal* 2010;3:16–30.
15. U.S. Conference of Catholic Bishops. *Assisted Suicide Laws in Oregon and Washington: What Safeguards?* September 22, 2016. Available at http://www.usccb.org/search.cfm?site=newusccb&proxystylesheet=newusccb_frontend&q=assisted+suicide&lang=eng. Accessed October 27, 2016.
16. Ganzini L, Back AL. The challenge of new legislation on physician-assisted death. *JAMA Intern Med* 2016;176:427–428.
17. Lerner BH, Caplan AL. Euthanasia in Belgium and the Netherlands: on a slippery slope? *JAMA Intern Med* 2015;175:1640–1641.
18. Aviv R. The death treatment. *New Yorker*;2015:June 22.
19. Miller DG, Kim SYH. Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgments. *BMJ Open* 2017;7:e017628.
20. Doernberg SN, Peteet JR, KIM SYH. Capacity evaluation of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics* 2016;57:556–565.
21. Gostin LO, Roberts AE. Physician-assisted dying: a turning point? *JAMA* 2016;315:249–250.

22. Nguyen HQ, Gelman EJ, Bush TA, Lee JA, Kanter MH. Characterizing Kaiser Permanente Southern California's experience with the California End of Life Option Act in the first year of implementation [research letter]. *JAMA Intern Med* 2017;December 26.
23. Li M, Watt S, Escaf M, et al. Medical assistance in dying: implementing a hospital-based program in Canada. *N Engl J Med* 2017;376:2082–2088.
24. Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences near the End of Life*. Washington, DC: The National Academies Press; 2015.
25. National Academies of Science, Engineering and Medicine. *Physician-Assisted Death: Scanning the Landscape and Potential Approaches*. Available at <https://www.nap.edu/download/25131#>. Accessed August 20, 2018.
26. Dzung E. Can growing popular support for physician-assisted death motivate organized medicine to improve end-of-life care? *J Gen Intern Med*. 2018;33:1209–1211.
27. Quill TE. Doctor, I want to die. will you help me? *JAMA* 1993;270:870–873.
28. Petrillo LA, Dzung E, Smith AK. California's End of Life Option Act: opportunities and challenges ahead. *J Gen Intern Med* 2016;31:828–829.

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

References:

1. The Williams Institute. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf>
2. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
3. Arkansas Driver Services instructions, <https://transequality.org/sites/default/files/docs/id/AR%20Drivers%20License%20gender%20change%20guidance.pdf>
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>.
11. New Jersey Babs Siperstein Law, https://www.njleg.state.nj.us/2018/Bills/A2000/1718_R2.PDF.
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>.
15. Colorado Change of Sex Designation, <https://www.colorado.gov/pacific/sites/default/files/DR2083.pdf>.
16. Connecticut Department of Public Health Statement, <https://www.cga.ct.gov/2019/PHdata/Tmy/2019SB-00388-R000225-Department%20of%20Public%20Health-TMY.PDF>.
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>
19. Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.

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

References:

1. Mohammed, K *et al.* Creating a Patient-Centered Health Care Delivery System: A Systematic Review of Health Care Quality From the Patient Perspective. *Amer. J of Med.* 2016; 31(1): 12-21.
2. Schwartz, D *et al.* Seeing the Person, Not the Illness: Promoting Diabetes Medication Adherence Through Patient-Centered Collaboration. *Clin. Diabetes.* 2017 Jan; 35(1): 35-42.
3. Tai-Seale, M *et al.* The Language of Engagement: "Aha!" Moments from Engaging Patients and Community Partners in Two Pilot Projects of the Patient-Centered Outcomes Research Institute. *Perm J.* 2016 Spring; 20(2): 89-92.
4. Wynia M and Matiasek J. Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals. *The Commonwealth Fund.* 2006.
5. Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. *Int J Obes (Lond).* 2013 Apr; 37(4): 612-9.
6. Noble AJ *et al.* 'Epileptic', 'epileptic person' or 'person with epilepsy'? Bringing quantitative and qualitative evidence on the views of UK patients and carers to the terminology debate. *Epilepsy & Behavior* 2017 Feb; 67: 20-27.
7. National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention. Disability Inclusion Strategies. 1 August 2017. Available at <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-strategies.html>, Accessed 6 September 2017.
8. Dunn, DS and Andrews, EE. Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *American Psychologist* 2015; 70(3): 255-264.
9. Botticelli MP and Koh HK. Changing the Language of Addiction. *JAMA.* 2016; 316(13): 1361-1362.
10. Obesity Action Coalition. Person-First Language for Obesity. 2017. Available at <http://www.obesityaction.org/weight-bias-and-stigma/people-first-language-for-obesity>, Accessed 19 September 2017.
11. National Alliance on Mental Illness. How to Be Inclusive and Welcoming. 2017. Available at <https://www.nami.org/Get-Involved/NAMI-FaithNet/How-to-Be-Inclusive-and-Welcoming>, Accessed 19 September 2017.
12. Psychiatric Rehabilitation Association. PRA Language Guidelines. 2002. Available at <https://www.nccdp.org/resources/PRALanguageGuidelines.pdf>, Accessed 6 September 2017.
13. Canadian Alzheimer's Society. Person-Centered Language. December 2012. Available at http://www.alzheimer.ca/~media/Files/national/Culture-change/culture_person_centred_language_2012_e.pdf, Accessed 6 September 2017.
14. Kapitan, A. On "Person-First Language": It's Time To Actually Put The Person First. *RadicalCopyEditor.com.* 3 July 2017. Available at <https://radicalcopyeditor.com/2017/07/03/person-centered-language/>, Accessed 6 September 2017.
15. Collier, R. Person-first language: Noble intent but to what effect? *CMAJ.* 2012 Dec 11; 184(18): 1977-1978.
16. Mackelprang, R. Cultural Competence in Persons with Disabilities. In: Lum, Doman, Ed. *Culturally Competent Practice. A framework for understanding diverse groups and justice issues.* 4th ed. Belmont, CA: Brooks/Cole CENGAGE Learning; 2011: 437-465.

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