

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinion was presented by James E. Sabin, MD, Chair.

1. AMENDMENT TO E-2.2.1, “PEDIATRIC DECISION MAKING”

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-I-18, “Amendment to E-2.2.1, ‘Pediatric Decision Making.’” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-2.2.1– Pediatric Decision Making

As the persons best positioned to understand their child’s unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children’s capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children’s physical health and well-being and to nurture their children’s developing personhood and autonomy.

But parents’ authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients’ assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child’s refusal to assent, and when circumstances permit should explore the child’s reason for dissent.

For health care decisions involving minor patients, physicians should:

- (a) Provide compassionate, humane care to all pediatric patients.
- (b) Negotiate with parents/guardians a shared understanding of the patient’s medical and psychosocial needs and interests in the context of family relationships and resources.
- (c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- (d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- (e) Provide a supportive environment and encourage parents/guardians to discuss the child’s health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.

- (f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
- (g) When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
- (h) When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–5, were presented by James E. Sabin, MD, Chair.

1. COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

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

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

DEFINING COMPETENCE

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

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

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

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

FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

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

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

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

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

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

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

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

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

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27]. Prevailing theory distinguishes

“fast” from “slow” thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [26]. Some scholars take expertise to involve “fast” processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [24]. Others argue that expertise consists in using “slow,” effortful, analytic processes to address problems [24]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment (“situational awareness”) and can determine when to shift to effortful processes [24].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [24], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

INFLUENCES ON CLINICAL REASONING

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

Heuristics

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

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

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [31]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting

information that does not fit into predetermined beliefs (confirmatory bias) [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

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

Overconfidence

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

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

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

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

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

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

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to "slow down" during a procedure is critical to competent

professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

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

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

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

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 [32]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

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

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

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

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician’s practice lifetime [38]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest

that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [38].

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

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

RECOMMENDATION

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

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

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

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

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

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

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2. PHYSICIAN-ASSISTED SUICIDE (RESOLUTION 15-A-16 AND RESOLUTION 14-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTIONS 15-A-16 AND 14-A-17
REMAINDER OF REPORT FILED
*See Opinion E-5.7***

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

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

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

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

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

The council observes that the ethical arguments advanced today supporting and opposing “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of [Opinion E-5.7](#), “Physician-Assisted Suicide,” in 1994.

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

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

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

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

COMMON GROUND

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

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient’s sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of [Principle I](#) of the *AMA Principles of Medical Ethics*: “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”

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

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

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

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

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

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging “substantive, coherent, and reasonably stable” values and principles within the profession and the wider moral community. While supporters and opponents of physician-assisted suicide share a common commitment to “compassion and respect for human dignity and rights” (AMA [Principles of Medical Ethics](#), I), they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and nuanced understanding of how to best honor and address the needs of people who are suffering” [11].

THE RISK OF UNINTENDED CONSEQUENCES

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

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

Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [17]. For example, research in the Netherlands

has found that “requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially reversible conditions might successfully end their lives.” At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a “slippery slope” [18].

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

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

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

SAFEGUARDING DECISIONS AT THE END OF LIFE

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

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

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

adequate resources for end-of-life care [16,28], particularly for patients from disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.

CONCLUSION

At the core of public and professional debate, the council believes, 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 and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease" [27]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

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

RECOMMENDATION

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

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

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, the Council on Ethical and Judicial Affairs recommends that the *Code of Medical Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted, and that the remainder of the report be filed.¹

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

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APPENDIX

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

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

3. CEJA'S SUNSET REVIEW OF 2009 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

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

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

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

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

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

2009 POLICIES

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

DUPLICATIVE POLICIES

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

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

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

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

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

RECOMMENDATION

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

APPENDIX - Recommended Actions

Policy No.	Title	Recommended Action & Rationale
D-105.998	Direct to Consumer Advertising D-105.998	<i>Rescind</i> <i>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.</i>
D-250.991	Victims of the War in Kosovo	<i>Rescind.</i> <i>Policy is outdated. The goal of this directive was originally accomplished by the establishment of the Physician Opportunities Portal, which has been discontinued.</i>
D-250.992	Medical Supply Donations to Foreign Countries	<i>Rescind.</i> <i>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/hti/appeal/medical_supplies/en/.</i>
D-315.994	Abuse of the Medical Record for Regulation or Financing the Practice of Medicine	<i>Rescind</i> <i>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</i>
D-315.996	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	<i>Rescind</i> <i>The goal of this directive is accomplished by extensive materials available at https://policysearch.ama-assn.org/policyfinder/search/HIPAA/relevant/1/</i>
D-373.998	Guidelines for Handling Derogatory Conduct in the Patient-Physician Relationship	<i>Rescind</i> <i>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.</i>
D-460.974	Office for Human Research Protections Interpretation of 45 CFR Part 46	<i>Rescind</i> <i>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).</i>
D-460.991	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	<i>Rescind</i> <i>This directive is outdated and is superseded by the revised Common Rule (2017).</i>
D-60.970	Disclosure of Health Status to Children and Adolescents	<i>Rescind</i> <i>The goal of this directive was accomplished by amendments to E-2.1.1, Pediatric Decision Making, adopted in 2010, 2018.</i>
D-70.954	Transition to ICD-10 Code Sets	<i>Rescind</i> <i>The goal of this directive is accomplished by extensive material available at https://www.ama-assn.org/search?search=ICD-10</i>
H-5.990	Policy on Abortion	<i>Reaffirm</i>

Policy No.	Title	Recommended Action & Rationale
H-65.985	Inappropriate Federal Prosecution	<i>Reaffirm</i>
H-140.921	Preserving the Traditional Patient-Physician Relationship	<i>Rescind</i> Policy is outdated and duplicative of guidance in the modernized Code of Medical Ethics (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	<i>Reaffirm</i>
H-140.949	Physician-Assisted Suicide	<i>Rescind</i> 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: 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)
H-140.952	Physician Assisted Suicide	<i>Reaffirm</i>
H-140.951 H-140.996	Professionalism and Medical Ethics Reaffirmation of Professionalism 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. 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.	<i>Consolidate and retitle:</i> 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.
H-190.958	Readability of Medical Notices of Privacy Practices	<i>Rescind</i> AMA provides sample language for notice of privacy practices at https://www.ama-assn.org/practice-management/hipaa/hipaa-privacy-security-resources
H-315.997	Patients' Access to Information Contained in Medical Records	<i>Rescind</i> Policy is outdated. HIPAA mandates patient access to their medical records.
H-315.998	Medical Record Privacy	<i>Rescind.</i> Policy adopted in 1979 is superseded by more recent law and regulation. AMA model legislation on this issue is no longer publicly available.

Policy No.	Title	Recommended Action & Rationale
H-350.971 H-350.975	Initiatives Regarding Minorities Improving Healthcare of Hispanic Populations in the United States	<p><i>Defer recommendation to 2019 Interim meeting pending review by Chief Health Equity Officer.</i></p> <p><i>Consider consolidating these and other policies that address identified patient populations and health disparities:</i></p> <p>H-160.991 Health Care Needs of Gay, Lesbian, Bisexual and Transgender Populations</p> <p>H-295.878 Eliminating Health Disparities—Promoting Awareness and Education of Lesbian, Gay, Bisexual and Transgender (LGBT) Issues in Medical Education</p> <p>H-350.957 Addressing Immigrant Health Disparities</p> <p>H-350.958 Hispanic Population and Access to the US Healthcare System</p> <p>H-350.959 Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities</p> <p>H-350.961 Improving the Health of Minority Populations</p> <p>H-350.966 Health Initiatives on Asian-Americans and Pacific Islanders</p> <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	<p><i>Rescind</i></p> <p><i>Superseded by AMA digital health resources at https://www.ama-assn.org/search?search=digital+health</i></p>
H-515.967	Protection of the Privacy of Sexual Assault Victims	<i>Reaffirm</i>

4. JUDICIAL FUNCTION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: ANNUAL REPORT

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at <https://www.ama-assn.org/governing-rules>.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX - CEJA Judicial Function Statistics, April 1, 2018 – March 31, 2019

Physicians Reviewed	<u>SUMMARY OF CEJA ACTIVITIES</u>
1	Determinations of no probable cause
50	Determinations following a plenary hearing
14	Determinations after a finding of probable cause, based only on the written record, after the physician waived their plenary hearing right
	<u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u>
10	No sanction or other type of action
4	Monitoring
9	Probation
17	Revocation
15	Suspension
4	Censure
4	Reprimand
2	Admonish
	<u>PROBATION/MONITORING STATUS</u>
6	Members placed on Probation/Monitoring during reporting interval
9	Members placed on Probation without reporting to Data Bank
18	Probation/Monitoring concluded satisfactorily during reporting interval
7	Memberships suspended due to non-compliance with the terms of probation
47	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
24	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

5. DISCRIMINATION AGAINST PHYSICIANS BY PATIENTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-65.991 provides that our AMA will study:

1. The prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests;
2. Hospitals' and other health care systems' policies or procedures for handling patient bias; and
3. The legal, ethical, and practical implications of accommodating or refusing such reassignment requests.

The Council on Ethical and Judicial Affairs (CEJA) was asked to develop guidance for physicians in response to this directive.

CEJA's review of relevant literature indicates that patient requests to be treated by a physician of a certain race, ethnicity, religion, sex, or other perceived characteristic may be driven by bias and bigotry, but it may also reflect cultural expectations or constraints, an individual's previous health care experiences, or the historical experiences of patient communities. How physicians and health care organizations should respond can depend significantly on the particular circumstances in which the request is made.

To adequately explore these complex issues, CEJA needs additional time to deliberate before presenting a report to the House of Delegates at the 2019 Interim Meeting.