

Reference Committee on Amendments to Constitution and Bylaws

CC&B Report(s)

- 01 Parity in our House of Delegates
- 02 Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies
- 03 AMA Delegate Apportionment

CEJA Report(s)

- 01 Competence, Self-Assessment and Self-Awareness
- 02 Amendment to E-1.2.2., "Disruptive Behavior by Patients"

Resolution(s)

- 001 Support for the Use of Psychiatric Advance Directives
- 002 Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training
- 003 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities
- 004 Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems
- 005 Removing Sex Designation from the Public Portion of the Birth Certificate
- 006 Transparency Improving Informed Consent for Reproductive Health Services
- 007 Addressing the Racial Pay Gap in Medicine
- 009 Data for Specialty Society Five-Year Review
- 010 Ban Conversion Therapy of LGBTQ Youth
- 011 End Child Marriage

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-19

Subject: Parity in our AMA House of Delegates

Presented by: Patricia L. Austin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2019 Annual Meeting, the House referred CCB Report 1, "Clarification to the Bylaws:
2 Delegate Representation, Registration and Credentialing," back to the Council for report back.
3 CCB Report 1-A-19 recommended a series of changes to the AMA Bylaws. To make consideration
4 and action easier for the House, the Council has broken its recommendations for bylaw
5 amendments into distinct reports, each of which deals with a specific aspect of the Bylaws. This
6 report focuses on parity between constituent societies and the national medical specialty societies.
7
8 The House of Delegates places great emphasis on the need for parity between the constituent
9 societies and the national medical specialty societies. Bylaw 2.10.5 states that the current president
10 of a constituent association may be certified as an additional alternate delegate at the discretion of
11 each constituent association. The Council notes that there is no corresponding bylaw whereby a
12 national medical specialty society or a professional interest medical association (PIMA) has that
13 same privilege. The Council has proposed an equivalent bylaw that would accord the same
14 opportunity. The Council also believes these additional alternate delegate positions may potentially
15 minimize vacant delegate seats for these entities.
16
17 Because of concern about potentially swelling the size of the House, the Council looked at the
18 registration and credentialing lists from the 2019 Annual Meeting of the House of Delegates. The
19 Council found that there were 9 national medical specialty societies/PIMAs that did not credential
20 a full complement of delegates, and 78 specialty societies/PIMAs that had anywhere from a single
21 alternate delegate vacancy to multiple alternate vacancies. To gain perspective about the frequency
22 by which constituent societies credential a president as an alternate delegate, the Council
23 discovered that at A-19 while 14 constituent societies credentialled a state medical society president
24 as an alternate delegate, 6 of those 14 individuals ultimately were no-shows. The Council
25 concluded that most national medical specialty societies/PIMA are unlikely to credential a
26 president as an alternate delegate, but it believes the option to do so should be provided to them.
27
28 RECOMMENDATIONS
29
30 The Council on Constitution and Bylaws recommends: 1) that the following amendments to the
31 AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the
32 affirmative vote of two-thirds of the members of the House of Delegates present and voting.

1 **2.10 Registration and Seating of Delegates.**

2
3 ***
4

5 **2.10.5 Constituent Association President.** The current president of a constituent
6 association may also be certified as an additional alternate delegate at the
7 discretion of each constituent association.

8
9 **2.10.6 National Medical Specialty Society or Professional Interest Medical**
10 **Association President.** The current president of a national medical specialty
11 society or a professional interest medical association may also be certified as an
12 additional alternate delegate at the discretion of each national medical specialty
13 society or professional interest medical association.

14
15 (Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-19

Subject: Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies

Presented by: Patricia L. Austin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2019 Annual Meeting, the House referred CCB Report 1, Clarification to the Bylaws:
2 Delegate Representation, Registration and Credentialing to the Council for report back. CCB
3 Report 1-A-19 recommended a series of changes to the AMA Bylaws. To make consideration and
4 action easier for the House, the Council has separated its recommendations for bylaw amendments
5 into distinct reports, each of which focuses on a specific revision to the Bylaws.

6
7 This report focuses on the delegate certification authority of the various Federation entities
8 represented in our House of Delegates as well as on the thirty-day requirement for advance
9 certification. The proposed changes aim for consistent language applicable to all represented
10 societies and groups.

11
12 **BACKGROUND**
13

14 A delegate certification process is essential in a democratic organization to ensure that only those
15 entitled to vote may do so, and that each delegate votes only once. Existing AMA bylaw provisions
16 use different terminology to identify the key individual(s) responsible for certifying the delegates
17 of each entity represented in our AMA House of Delegates. For constituent associations and the
18 national medical specialty societies, the bylaws accord certification responsibility to the president
19 or secretary. The bylaws for the AMA Sections, military services and the professional interest
20 medical associations put the responsibility for certification on the president, secretary or other
21 authorized individual. With respect to the medical student regional delegates and the delegates
22 from the Resident and Fellow Section, the bylaws designate the section chair as the authorized
23 individual for purposes of credentialing. In addition, another bylaw allows the RFS chair to
24 delegate the task; however, there is no such provision for the MSS chair to delegate authority for
25 credentialing.

26
27 The Council has proposed amendments to several bylaw provisions to make the certification
28 authority more consistent across the different entities represented in our House of Delegates. The
29 Council also notes, that while a president is generally recognized as the representative of an
30 organization, not every organization has the position of President. Furthermore, certain duties and
31 responsibilities may be delegated. With regard to the certification authority, it is typically the
32 executive director or other staff person who confirms the entity's representatives to the House of
33 Delegates.

34
35 With regard to the timing of the certification, existing provisions of our AMA Bylaws currently
36 state that certification must occur at least 30 days prior to the Annual or Interim Meeting of the
37 House of Delegates. The Office of the House of Delegates Affairs works diligently with the

1 Federation to manage the process to ensure that all certifications are received 30 days prior to the
2 meeting. The names of the credentialed delegates and alternate delegates become part of the
3 Official Call, which is disseminated to all House of Delegates representatives in advance of the
4 meeting, included in the House of Delegates Handbook, incorporated into the AMA Pictorial
5 Directory, and used as a starting point for the final list published in the meeting proceedings. In
6 proposing to modify Bylaw 2.6.1, the Council is paralleling language that exists elsewhere for the
7 constituent societies and the national medical specialty societies. Also, the bylaw change will not
8 change current practice with respect to professional interest medical associations, the sections or
9 the federal services.

10
11 The Council stresses that the 30-day advance certification requirement does not preclude late or
12 onsite certification and applies equitably to all. When credentialed individuals find themselves
13 unable to attend the meeting or have an emergency that precludes their participation, existing
14 bylaws appropriately provide for those situations. Bylaw 2.10.3, Lack of Credentials, permits a
15 delegate or alternate delegate to be seated/credentialed onsite provided proper identification is
16 established and so certified to the AMA. Furthermore, Bylaw 2.10.4 provides for a “substitute
17 delegate” when a delegate or alternate delegate is unable to attend a meeting. Bylaw 2.10.4.1
18 provides for “a temporary substitute delegate” when a delegate is not able to remain in attendance
19 for the entire meeting. The Council also has proposed editorial amendments to these bylaws for
20 consistency, accuracy and simplicity.

21
22 RECOMMENDATIONS
23

24 The Council on Constitution and Bylaws recommends: 1) that the following amendments to the
25 AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the
26 affirmative vote of two-thirds of the members of the House of Delegates present and voting.

27
28 **2.1.4 Certification.** The president ~~or secretary~~ of each constituent association, or the
29 ~~president's designee,~~ shall certify to the AMA the delegates and alternate delegates
30 from their respective associations. Certification must occur at least 30 days prior to
31 the Annual or Interim Meeting of the House of Delegates.

32 ***

33
34 **2.2.4 Certification.** The president ~~or secretary~~ of each specialty society, or the
35 ~~president's designee,~~ shall certify to the AMA the delegates and alternate delegates
36 from their respective societies. Certification must occur at least 30 days prior to the
37 Annual or Interim Meeting of the House of Delegates.

38 ***

39
40 **2.3.4 Certification.** The Chair of the Medical Student Section Governing Council, or the
41 ~~Chair's designee,~~ shall certify to the AMA the delegates and alternate delegates ~~for~~
42 ~~from~~ each Medical Student Region. Certification of delegates and alternate
43 delegates must occur at least 30 days prior to the Annual Meeting of the House of
44 Delegates.

45 ***

1 **2.4.4 Certification.** The Chair of the Resident and Fellow Section Governing Council,
2 or his or her the Chair's designee, shall certify to the AMA the delegates and
3 alternate delegates for the Resident and Fellow Section. Certification of delegates
4 and alternate delegates must occur at least 30 days prior to the Annual Meeting of
5 the House of Delegates.

6 ***

7

8 **2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections; the
9 Surgeons General of the United States Army, United States Navy, United States Air Force,
10 and United States Public Health Service; the Chief Medical Director of the Department of
11 Veterans Affairs; the National Medical Association; the American Medical Women's
12 Association; the American Osteopathic Association; and professional interest medical
13 associations granted representation in the House of Delegates.

14

15 **2.6.1 Certification.** The president, secretary or other authorized individual of each entity
16 shall certify to the AMA their respective delegate and alternate delegate.
17 Certification must occur 30 days prior to the Annual or Interim Meeting.

18

19 **2.10 Registration and Seating of Delegates.**

20

21 ***

22

23 **2.10.2 Credentials.** A delegate or alternate delegate may only be seated if there is Before
24 being seated at any meeting of the House of Delegates, each delegate or alternate
25 delegate shall deposit with the Committee on Rules and Credentials a certificate
26 certification on file signed by the president, secretary, or other authorized
27 individual of the delegate's or alternate delegate's organization stating that the
28 delegate or alternate delegate has been properly selected to serve in the House of
29 Delegates.

30

31 **2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the
32 certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or
33 alternate delegate selected by the respective organization entity is established, and
34 so certified to the AMA.

35

36 **2.10.4 Substitute.** When a delegate or alternate delegate is unable to attend a meeting of
37 the House of Delegates, the appropriate authorities president, the president's
38 designee or other authorized individual of the organization entity may appoint a
39 substitute delegate or substitute alternate delegate, who on presenting proper
40 credentials shall be eligible to serve as such delegate or alternate delegate in the
41 House of Delegates at that meeting.

42

43 **2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have
44 been accepted by the Committee on Rules and Credentials and whose
45 name has been placed on the roll of the House of Delegates shall
46 remain a delegate until final adjournment of that meeting of the House
47 of Delegates. However, if the delegate is not able to remain in
48 attendance, that place of that delegate may be taken during the period of
49 absence by an alternate delegate, or a substitute alternate delegate
50 selected in accordance with Bylaw 2.10.4 if an alternate delegate is not
51 available. The person who takes the place of the delegate must comply

with the formal recredentialing procedures established by the Committee on Rules and Credentials for such purpose have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

* * *

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

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-19

Subject: AMA Delegation Apportionment

Presented by: Patricia L. Austin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2018 Interim Meeting, Policy G-600.016, “Data Used to Apportion Delegates,” was
2 adopted. Among its recommendations were that “pending members” be added to the number of
3 active AMA members in the December 31 count for the purposes of AMA delegate allocations to
4 national medical specialty and state medical societies for the following year.” At the 2019 Annual
5 Meeting, Policy G-600.016 subsequently was amended to read as follows: “Pending members” will
6 be added to the number of active AMA members in the December 31 count for the purposes of
7 AMA delegation allocations to state medical societies for the following year and this total will be
8 used to determine the number of national medical specialty delegates to maintain parity.” The body
9 of the report defines “pending members” as individuals who at the time they apply for membership
10 are not current in their dues and who pay dues for the following calendar year. Board of Trustees
11 Report 12-A-19, which proposed the adopted modification,” also called for a report to the House at
12 the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding
13 continuation of this policy. The Council on Constitution and Bylaws was directed to prepare a
14 report with bylaw amendments for the 2019 Interim Meeting to allow the implementation of Policy
15 G-600.016.

16

17 The Council on Constitution and Bylaws presents the requested amendments to the AMA Bylaws.
18 It also will include a definition of “pending members” in the glossary to the Bylaws.

19

20 RECOMMENDATIONS

21

22 The Council on Constitution and Bylaws recommends the following:

23

24 1. That the following amendment to the AMA Bylaws be adopted. Adoption requires the
25 affirmative vote of two-thirds of the members of the House of Delegates present and voting.

26

27 **2.1 Constituent Associations.** Each recognized constituent association granted representation
28 in the House of Delegates is entitled to delegate representation based on the number of
29 seats allocated to it by apportionment, and such additional delegate seats as may be
30 provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state,
31 commonwealth, territory, or possession shall be granted representation in the House of
32 Delegates.

33

34 **2.1.1 Apportionment.** The apportionment of delegates from each constituent
35 association is one delegate for each 1,000, or fraction thereof, active constituent
36 and active direct members of the AMA within the jurisdiction of each constituent
37 association, as recorded by the AMA as of December 31 of each year.

1 2.1.1.1 The December 31 count will include pending members for purposes of
2 apportionment; however, pending members shall not be recounted the
3 following year absent membership renewal. This Bylaw will sunset as of
4 the close of business of the 2022 Interim Meeting unless the House of
5 Delegates acts to retain it.

6

7 [Subsequent bylaw provisions shall be renumbered] (Modify Bylaws)

8

9 2. That Policy G-600.016(2) be amended by addition to read as follows:

10

11 “Pending members” (defined as individuals who at the time they apply for membership are not
12 current in their dues and who pay dues for the following calendar year) will be added to the
13 number of active AMA members in the December 31 count for the purposes of AMA delegate
14 allocations to state medical societies for the following year and this total will be used to
15 determine the number of national medical specialty delegates to maintain parity. (Modify
16 Current HOD Policy)

17

18 3. That the remainder of this report be filed.

Fiscal Note: Less than \$500

AMA Policy

G-600.016, Data Used to Apportion Delegates

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. “Pending members” will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track “pending members” from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-I-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-I-19

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: Kathryn L. Moseley, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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-
34 career physicians or physicians who are changing or re-entering practice or transitioning out of

* 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 active practice to other roles. Each phase of a medical career, from medical school through
2 retirement, carries its own implications for what a physician should know and be able to do to
3 practice safely and to maintain effective relationships with patients and with colleagues.
4

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

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

12

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

21 Self-assessment has thus become integral to many appraisal systems [5, 10, 12-16]. Yet clinicians
22 and trainees tend to assess their peers’ performance more accurately than they do their own—for
23 example, those who perform in the bottom quartile tend to over-estimate their abilities, while those
24 in the top quartile tend to under-estimate themselves [5,12,13,17].
25

26 Self-assessment involves an interplay of factors that can be complicated by personal characteristics
27 (e.g., gender, ethnicity, or cultural background); by lack of insight or ability to be self-observant in
28 the moment; and by external factors, such as the purpose of self-assessment [12,18]. The published
29 literature also indicates that interventions intended to enhance self-assessment may seek different
30 goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting
31 appropriate change in learning activities, or improving clinical practice or patient outcomes [12].
32

33 Thus self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe,
34 high quality care. Feedback from third parties is essential [19]. However, physicians can be hesitant
35 to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of
36 concern that soliciting feedback could adversely affect their relationships with those whom they
37 approach [20]. They may also question the accuracy and credibility of the assessment process and
38 the data it generates [21]. And they are not sure how to use information that is not congruent with
39 their self-appraisals [20].
40

41 To be effective, feedback must be valued by those being assessed as well as by those offering
42 assessment [14]. When there is tension between the stated goals of assessment and the implicit
43 culture of the health care organization or institution, assessment programs can too readily devolve
44 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
45 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
46 (“360° reviews”), for example, are generally better suited to providing feedback on communication
47 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
48 understand and use [14]. High quality feedback will come from multiple sources; be specific and
49 focus on key elements of the ability being assessed; address behaviors rather than personality or
50 personal characteristics; and “provide both positive comments to reinforce good behavior and
51 constructive comments with action items to address deficiencies” [22]. Beyond such formal

1 mechanisms, physicians should welcome and seek out informal input from colleagues. They should
2 be willing to offer timely comments to colleagues as well.

3
4 One study among physicians and trainees found that participants interpreted and responded to
5 multiple types of information, such as cognitive and affective data, from both formal and informal
6 sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or
7 throughout the day”:

8
9 I think we do a lot of it without thinking of it as reflection. We do it every day when we look at
10 a patient’s chart. You look back and see the last visit, “What did I do, or should I have done
11 something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-
12 assessment or self-reflection, but we do it dozens of times a day [23].

13
14 EXPERTISE & EXPERT JUDGMENT

15
16 On this broad understanding of competence, physicians’ thought processes are as important as their
17 knowledge base or technical skills. Thus, understanding competence requires understanding
18 something of the nature of expertise and processes of expert reasoning, themselves topics of
19 ongoing exploration [24,25,26,27].

20
21 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
22 automatic resources and to transition appropriately to a greater reliance on effortful processes when
23 needed” [24], a practice described as “slowing down.” Knowing when to slow down and be
24 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To
25 respond to the unexpected events that often arise in a clinical situation, the physician must
26 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
27 transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts
28 an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
29 serves as a critical marker for intraoperative surgical judgment [24].

30
31 *Influences on Clinical Reasoning*

32
33 Physicians’ skills of clinical reasoning develop through education, training, and experiences. Every
34 physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
35 differ from the analytical and investigative processes of their colleagues in innumerable ways.
36 Nonetheless, all physicians are susceptible to certain common pitfalls in reasoning, notably relying
37 unduly on heuristics and habits of perception, and succumbing to overconfidence.

38
39 Physicians use time-saving cognitive short cuts (heuristics) to help identify and categorize relevant
40 information. But such short cuts can also mislead physicians to miscategorize information based on
41 seeming similarity or to place too much weight “on examples of things that come to mind easily
42 [28]. Other common cognitive missteps can derail clinical reasoning as well, including
43 misperceiving a coincidental relationship as a causal one, or the tendency to remember information
44 transferred at the beginning or end of an exchange but not information transferred in the middle
45 [28,29,30].

46
47 Like every other person, physicians can also find themselves prone to conscious or unconscious
48 habits of perception or biases. They may allow unquestioned assumptions based on a patient’s race
49 or ethnicity, gender, socioeconomic status, or health behavior, for example, to shape how they
50 perceive the patient and how they engage with, evaluate, and treat the individual [31]. Physicians
51 may fall victim to the tendency to seek out information that confirms established expectations or

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

4
5 So too, despite their extensive training, physicians, like all people, are often poor at identifying the
6 gaps in their knowledge [28,30]. They may consider their skills to be excellent, when, in fact, their
7 peers have identified areas for improvement [30]. Overconfidence in one's abilities can lead to
8 suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of
9 others, or not acknowledging one's limits [28,30].

10
11 Physicians should be aware of the information they do and do not have and they acknowledge that
12 many factors can and will influence their judgment. They should keep in mind the likelihood of
13 diseases and conditions and take the time to distinguish information that is truly essential to sound
14 clinical judgment from the wealth of possibly relevant information available about a patient. They
15 should consider reasons their decisions may be wrong and seek alternatives, as well as seek to
16 disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in
17 which assumptions may color their reasoning and not allow expectations to govern their
18 interactions with patients.

19
20 Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming
21 aware of areas in which their skills are not at their strongest and seeking additional education or
22 consulting with colleagues, physicians can enhance their practice and best serve their patients.

23
24 **FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS**

25
26 Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally
27 conceived has significant shortcomings, several scholars have argued that a different understanding
28 of self-assessment is needed, along with a different conceptualization of its role in a self-regulating
29 profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's
30 weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit
31 practice in areas in which one has limited competence, to help set appropriate learning goals, and to
32 identify areas that "should be accepted as forever outside one's scope of competent practice" [32].
33 Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence"
34 and to "set appropriately challenging learning goals" that push the boundaries of the physician's
35 knowledge [32].

36
37 If self-assessment is to fulfill these functions, physicians need to reflect on past performance to
38 evaluate not only their general abilities but also specific completed performances. At the same
39 time, they must use self-assessment predictively to assess how likely they are to be able to manage
40 new challenges and new situations. More important, physicians should understand self-assessment
41 as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in
42 the moment is critical to physicians' ethical responsibility to practice safely, at the top of their
43 expertise but not beyond it.

44
45 Self-awareness, in the form of attentive self-observation, alerts physicians when they need to direct
46 additional cognitive resources to the immediate task. For example, among surgeons, knowing when
47 to "slow down" during a procedure is critical to competent professional performance, whether that
48 means actually stopping the procedure, withdrawing attention from the surrounding environment to
49 focus more intently on the task at hand, or removing distractions from the operating environment
50 [25].

1 Physicians should also be sensitive to the ways that interruptions and distractions, which are
2 common in health care settings, can affect competence in the moment [34,35], by disrupting
3 memory processes, particularly the “prospective memory”—i.e., “a memory performance in which
4 a person must recall an intention or plan in the future without an agent telling them to do so”—
5 important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to
6 help reduce the number or type of interruptions and distractions and mitigate their impact on
7 medical errors [37].
8

9 A key aspect of competence is demonstrating situation-specific awareness in the moment of being
10 at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking
11 things up, consulting a colleague, or deferring from taking on a case can all be appropriate
12 responses when physicians’ self-awareness tells them they are at the limits of their abilities. The
13 capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of
14 competence broadly understood:
15

16 Safe practice in a health professional’s day-to-day performance requires an awareness of when
17 one lacks the specific knowledge or skill to make a good decision regarding a particular patient
18 This decision making in context is importantly different from being able to accurately rate
19 one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that
20 self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
21 self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and
22 continuously monitoring one’s ability to effectively solve the current problem [32].
23

24 Self-aware physicians discern when they are no longer comfortable handling a particular type of
25 case and know when they need to obtain more information or need additional resources to
26 supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—
27 the death of a loved one or other family crisis, or the reorganization of their practice, for example—
28 may be affecting their ability to provide care appropriately at a given time. They recognize when
29 they should ask themselves whether they should postpone care, arrange to have a colleague provide
30 care, or otherwise find ways to protect the patient’s well-being.
31

32 Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of
33 course. In some circumstances, self-awareness may be impaired to the point that individuals are not
34 aware of, or deny, their own health status and the adverse effects it can or is having on their
35 practice. In such circumstances, individuals must rely on others—their personal physician,
36 colleagues, family, social acquaintances, or even patients—to help them recognize and address the
37 situation. Physicians have a responsibility to one another and to patients to promote health within
38 the physician community, a responsibility that extends to intervening when a colleague’s ability to
39 practice safely is compromised [E-9.3.2]. Physicians who are unable to recognize that they are
40 impaired due to cognitive disability or other illness are not necessarily blameworthy or unethical,
41 unless they decline to address their condition and modify their practice once others have drawn
42 attention to their inability to continue practicing medicine safely.
43

44 MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME
45

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

1 A variety of strategies is available to physicians to support effective self-assessment and help them
2 cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day
3 practice. One such strategy might be to create a portfolio of materials for reflection in the form of
4 written descriptions, audio or video recording, or photos of encounters with patients that can
5 provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve
6 practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized
7 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”—being fully present in everyday experience and aware of one’s own mental
26 processes (including those that cloud decision making) [39]—sustains the attitudes and skills that
27 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. Physicians can
30 cultivate mindfulness in myriad ways; e.g., through meditation, keeping a journal, reviewing videos
31 of encounters with patients, or seeking insight from critical incident reports [39].
32

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

38 RECOMMENDATION

39

40 Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the
41 following be adopted and the remainder of this report be filed:
42

43 The expectation that physicians will provide competent care is central to medicine. It
44 undergirds professional autonomy and the privilege of self-regulation granted by society. To
45 this end, medical schools, residency and fellowship programs, specialty boards, and other
46 health care organizations regularly assess physicians’ technical knowledge and skills.
47

48 However, as an ethical responsibility competence encompasses more than medical knowledge
49 and skill. It requires physicians to understand that as a practical matter in the care of actual
50 patients, competence is fluid and dependent on context. Each phase of a medical career, from
51 medical school through retirement, carries its own implications for what a physician should

1 know and be able to do to practice safely and to maintain effective relationships with patients
2 and with colleagues. Physicians at all stages of their professional lives need to be able to
3 recognize when they are and when they are not able to provide appropriate care for the patient
4 in front of them or the patients in their practice as a whole.

5
6 To fulfill the ethical responsibility of competence, individual physicians and physicians in
7 training should strive to:

8
9 (a) Cultivate continuous self-awareness and self-observation.
10
11 (b) Recognize that different points of transition in professional life can make different
12 demands on competence.
13
14 (c) Take advantage of well-designed tools for self-assessment appropriate to their practice
15 settings and patient populations.
16
17 (d) Seek feedback from peers and others.
18
19 (e) Be attentive to environmental and other factors that may compromise their ability to bring
20 appropriate skills to the care of individual patients and act in the patient's best interest.
21
22 (f) Maintain their own health, in collaboration with a personal physician, in keeping with
23 ethics guidance on physician health and wellness.
24
25 (g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to
26 practice safely is compromised by impairment, in keeping with ethics guidance on
27 physician responsibilities to impaired colleagues.

28
29 Medicine as a profession should continue to refine mechanisms for assessing knowledge and
30 skill and should develop meaningful opportunities for physicians and physicians in training to
31 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 <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. 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 <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. 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 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-19

Subject: Amendment to E-1.2.2, "Disruptive Behavior by Patients"

Presented by: Kathryn L. Moseley, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy D-65.991, "Discrimination against Physicians by Patients," directs the American Medical
2 Association (AMA) to study "(1) the prevalence, reasons for, and impact of physician,
3 resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and
4 other health care systems' policies or procedures for handling patient bias; and (3) the legal,
5 ethical, and practical implications of accommodating or refusing such reassignment requests."
6

7 The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics
8 concerns in this area and offers guidance for physicians when they encounter patients who refuse or
9 demand care based on the physician's perceived personal, rather than professional, characteristics.
10

11 REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE 12

13 It is not known just how often patients discriminate against or sexually harass physicians (and other
14 health care personnel) as data are not systematically collected or publicly reported. However, a
15 growing number of studies and an expanding body of anecdotal reports suggest that such behavior
16 is pervasive in health U.S. care [e.g., 1-7]. In the words of one analyst discrimination by patients is
17 medicine's "open secret" [4].
18

19 A survey conducted jointly by Medscape and WebMD in 2017 found that 59% of respondents
20 overall heard an offensive remark from a patient about the physician's personal characteristic,
21 including comments about the physician's weight and political views in addition to comments
22 about age, ethnicity or national origin, gender, race, and sexual orientation [8]. Emergency
23 physicians were significantly more likely to report having experienced bias (83%) than primary
24 care physicians (62%) or specialists (59%). Among respondents, more African American (70%),
25 Asian (69%), and Hispanic (63%) physicians reported hearing biased comments compared to white
26 physicians (55%). The same survey found that male and female physicians experience bias
27 differently, notably in terms of the physician characteristics targeted. For example, female
28 respondents reported experiencing bias more often on the basis of their gender or age than male
29 physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced
30 bias based on their ethnicity or religion somewhat more often than their female colleagues (24%
31 versus 20% and 15% versus 8%, respectively).

*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 A variety of factors can drive patient behavior that is disrespectful, derogatory, or prejudiced,
2 including mental illness or incapacity or individual life experience, as well as personal beliefs and
3 bias. Different drivers carry different implications for whether, or to what degree, patients can
4 reasonably be held responsible for their problematic behavior. It would not be appropriate to hold
5 patients responsible or blameworthy for statements or actions that are not the product of rational
6 thought in the moment [9]. Thus, physicians' first response to problematic behavior should to
7 explore the reasons underlying the behavior so that they can identify, appreciate, and address
8 potentially treatable conditions. Behavior that outright threatens the safety of health care personnel
9 or other patients calls for prompt action to de-escalate the situation or remove the threat [e.g., 10,
10 11].

11
12 Lingering systemic racism and health disparities in the United States shape the experience of both
13 patients and health care professionals, especially those from nondominant communities [1, 3, 12].
14 Against this background, patients' reasons for refusing care by a specific physician or requesting a
15 different physician cover a "spectrum of justifiability" [13].

16
17 Requests not to be treated by a specific physician may reflect fears or concerns about care that are
18 rooted in systemic discrimination against members of the patient's community or traumatic
19 experiences in a patient's personal history [4, 9, 13]. Requests *for* a physician concordant in
20 ethnicity, religion, or gender may reflect cultural preferences or traditions, for example, a Muslim
21 woman's preference to receive care from a female physician. Such requests may also reflect
22 patients' experience, or reasonable expectation, that they will be better understood by a physician
23 "like them." Evidence suggests that at least for some patients, racial/ethnic or cultural concordance
24 between patient and physician supports more effective communication, enhances satisfaction, and
25 may have clinical benefit [4]. In these situations, it is appropriate to respect patient concerns and
26 preferences, when doing so is clinically feasible.

27
28 Requests for an alternative physician based solely on prejudice against personal characteristics of
29 the physician, however, are not justifiable and need not—perhaps should not—be accommodated
30 [4, 9, 13]. Requests based on a physician's (actual or perceived) race/ethnicity, national origin,
31 creed, gender identity, sexual orientation, disability, or other personal characteristic are ethically
32 objectionable.

33
34 For physicians and health care institutions faced with patients' strongly held views about who
35 should provide care, then, a central task is distinguishing when a patient's stated preference rests on
36 ethically acceptable reasons and when it reflects unacceptable bias or prejudice. When, that is, will
37 accommodation serve important patient interests and when will it reinforce problematic stereotypes
38 and, in effect if not intent, condone bigotry [2, 9]?

39
40 **PROTECTING INTERESTS, MINIMIZING HARMS**

41
42 Patient refusals of care or demands for alternative caregivers challenge physicians, and the
43 institutions in which they work, to protect both the interests of patients and those of physicians. In
44 such situations, physicians' professional obligations to promote patient well-being, respect patients
45 as moral agents and autonomous decision makers, and fulfill the duty to treat without
46 discrimination come into tension in potentially novel ways. Nor do these responsibilities align with
47 physicians' own interests in upholding professional autonomy and themselves being free from
48 discrimination. There are potential harms to both parties whether the physician/institution
49 accommodates bigoted requests and removes the caregiver or requires patient and physician to
50 engage one another in a troubled relationship.

1 Physicians' fiduciary obligations are fundamental. Physicians are expected to promote patients' interest and well-being without regard to individuals' personal characteristics or behavior, up to and including providing care to individuals whose behavior may be morally repugnant [13, 14].
2 But whether continuing to provide care or allowing oneself to be withdrawn from a case better fulfills that fiduciary obligation is only intelligible in the individual case. So too are interpretations of how a physician is to respect the autonomy of a patient who asserts moral agency in the form of prejudice, and what the duty to care entails when the recipient behaves in a way that, arguably, is not morally worthy or acceptable. Reaching sound determinations in these matters cannot be done by rote; instead, as one commentator observed, doing so calls for "nuanced ethical judgment" [13].
3
4 The American Medical Association *Code of Medical Ethics* enjoins physicians to provide "competent medical care, with compassion and respect for human dignity and rights" [15]. It also acknowledges that, except in emergencies, physicians shall be "free to choose whom to serve" [16].
5
6 The Code further delineates the conditions under which a physician may decline to accept a new patient (or provide a specific service to an existing patient [17]. These include when the care requested is outside the physician's competence or scope of practice; when the physician lacks the resources to provide safe, competent, respectful care for the individual; and when meeting this patient's medically needs seriously compromises the physician's ability to provide the care needed by other patients. Importantly, guidance acknowledges that, except in emergencies, a physician may decline to provide care when the patient "is abusive or threatens the physician, staff, or other patients" [17]. At the same time, the *Code* provides that physicians may terminate a relationship with a patient who "uses derogatory language or acts in a prejudicial manner *only if the patient will not modify the behavior*," in which case the physician should arrange to transfer the patient's care [emphasis added] [18].
7
8 One approach to determining the ethically appropriate response to prejudiced behavior by patients is to explore the harms—to patients, to physicians and other health care professionals, and to health care institutions and even the wider community—that can result from different possible responses. Who, that is, is harmed by a given response, and in what way?
9
10 Thwarting the requests of seemingly bigoted patients for alternative caregivers exposes patients to possible delays in care and poorer health outcomes, should they choose to leave the facility (with or without assistance from the institution). If they do not, or cannot leave, patients are subjected to the experience of receiving medical care from a physician against whom they are biased.
11 Distinguishing between a preference for a different physician and a demand for one is important in thinking about the nature and degree of harm the patient may experience. A preference is "an expression of an inclination that may be gratified or not"; a demand is "more of an ultimatum, in which failure to meet its indicia may be met not only with disappointment but also anger and resentment" [9]. Further, it is important to determine why the patient is making the request/demand, which may have a clinical source, such as delirium, dementia, or psychosis [4, 13], that is outside the patient's control, as opposed to being a stance the patient has voluntarily adopted. And as noted previously, requests/demands may also reflect life experiences that color a patient's response to caregivers for which accommodation may be appropriate.
12
13 For physicians and other caregivers, acceding to bigoted demands can send powerful, but unintended and potentially hurtful messages—that minority or female physicians are "not as good" as white male physicians or that patient satisfaction scores are more important to the institution than promoting a safe and ethical working environment [1, 19]. Accommodating bigotry can make institutions complicit in discrimination [19], in the process tacitly condoning or reinforcing an

1 institutional culture that routinely subjects minority physicians to “barrages of microaggressions
2 and biases” or expects them to serve as “race/ethnicity ambassadors” [1].
3
4 Institutions that fail to support staff in the face of prejudice convey that complying with patient
5 demands “is more important than respecting the dignity of both their staff members and the
6 majority of patients, who do not hold such repugnant views (or at least do not openly act on them)”
7 [9]. Institutions, some argue, “have a duty to present a moral face to their community by refusing to
8 honor bigoted or prejudicial requests or demands as a matter of course, up to and including
9 declining to care for such patients (except in emergency situations)” [9, cp. 20].
10
11 Regardless of how their institutions respond, for many minority health care professionals,
12 interactions with prejudiced patients are painful and degrading and contributed to moral distress
13 and burnout [4]. *Requiring* physicians to provide care when a patient has openly expressed bias is
14 not ethically tenable. As one physician described his own experience of ultimately declining to
15 work with a particular patient, “After years of feeling that my race was a nonissue, I was subjected
16 to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not
17 having thicker skin began to creep in, I decided that, on this occasion, my feelings would count”
18 [21]. Absent unique situations, institutions should allow physicians to control the decision about
19 whether they will continue to provide care [19]. Some have argued that institutions have a
20 responsibility to monitor such encounters and their effects on an ongoing basis “with the goal of
21 supporting staff and improving the handling of these situations” [4].
22
23 Whether patient prejudice against physicians adversely affects quality of care has not been well
24 studied. One experimental study among family practice physicians in the Netherlands concluded
25 that “disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors”
26 [22]. A companion study attributed this to the fact that the “mental resources” devoted to dealing
27 with patient behavior interfered with “adequate processing of clinical findings” [23]. Evidence does
28 indicate that physician “burnout” can adversely affect patient outcomes [e.g., 24–26]. To the extent
29 that being the target of patient prejudice contributes to the emotional exhaustion, sense of
30 depersonalization, and sense of low personal accomplishment characteristic of burnout, it is
31 reasonable to expect biased behavior to be associated with lower quality of care, particularly if
32 targeted physicians feel they do not have the support of their colleagues or institutions when bias
33 occurs [1, 21, 27, 28].
34
35 **LAW AND POLICY**
36
37 Legally, at the federal level how a health care institution responds to prejudiced behavior by
38 patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act*
39 (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA).
40 When patients make requests based on the physician’s race, hospitals are in the position of having
41 to meet EMTALA requirements while respecting physicians’ employment rights [4]. Hospitals can
42 “inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful
43 speech,” but their ability “to remove physicians in response to race-based requests is
44 circumscribed” [4]. Although physicians have not sued under CRA [4], in a case that ultimately
45 settled, an African-American nurse in Michigan sued her employer when she was barred from
46 caring for a white baby at the request of the child’s father, a white supremacist [29].
47
48 At present, relatively few institutions have formal policy or procedures for dealing with incidents
49 of patient prejudice, although an increasing number broadly enjoin patients to behave in a
50 respectful manner under policies delineating patient rights and responsibilities and indicate that
51 misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto’s University

1 Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of
2 patients and health care personnel.

3
4 UHN's *Caregiver Preference Guidelines* focus on three key questions: whether the preference for
5 an alternative caregiver appears to discriminate against the health care professional on the basis of
6 race, ancestry or other characteristic as provided in the *Ontario Human Rights Code*; whether the
7 request is clinically feasible and/or indicated to a reasonable degree; and whether the caregiver
8 wishes to excuse themselves from caring for the patient [27]. Mayo's recently adopted policy
9 directs staff to step in when they observe behavior that is not in keeping with Mayo Clinic values;
10 address the behavior with the patient, focusing the conversation on Mayo's published values;
11 explain the institution's expectations and set boundaries with the individual; and report the incident
12 to supervisors and document it via a patient misconduct form [27].

13
14 RECOMMENDATION

15
16 In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that
17 Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; Opinion 1.2.2,
18 "Disruptive Behavior by Patients," be amended by addition and deletion as follows; and the
19 remainder of this report be filed:

20
21 The relationship between patients and physicians is based on trust and should serve to promote
22 patients' well-being while respecting ~~their~~ the dignity and rights of both patients and
23 physicians.

24
25 Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for
26 accommodation of personal preferences on the part of either physicians or patients can
27 undermine trust and compromise the integrity of the patient-physician relationship. It can make
28 members of targeted groups reluctant to seek or provide care, and create an environment that
29 strains relationships among patients, physicians, and the health care team.

30
31 Trust can be established and maintained only when there is mutual respect. Therefore, in their
32 interactions with patients, physicians should:

33
34 (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause
35 psychological harm to those ~~they target~~ who are targeted.

36
37 (b) Always treat patients with compassion and respect.

38
39 (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced
40 ways. Physicians should identify, appreciate, and address potentially treatable clinical
41 conditions or personal experiences that influence patient behavior. Regardless of cause,
42 when a patient's behavior threatens the safety of health care personnel or other patients,
43 steps should be taken to de-escalate or remove the threat.

44
45 (d) In general, decline to accommodate patient requests for an alternative physician when the
46 request is solely the product of prejudice against the physician's personal characteristics.

47
48 (e) Consider accommodating a patient's request for an alternative physician when the request
49 derives from the patient's adverse personal experience, doing so would promote effective
50 care, and another appropriately qualified physician is available to provide the needed care.

1 (f) In emergency situations, patients who persist in opposing treatment from the physician
2 assigned may be helped to seek care from other sources. When transfer is not feasible,
3 patients should be informed that care will be provided by appropriately qualified staff
4 independent of the patient's expressed preference.

5

6 (eg) Terminate the patient-physician relationship with a patient ~~who uses derogatory language~~
7 ~~or acts in a prejudiced manner~~ whose volitional behavior is disrespectful, derogatory, or
8 prejudiced only if the patient will not modify the conduct. In such cases, the physician
9 should arrange to transfer the patient's care when that is feasible.

10

11 Physicians, especially those in leadership roles, should encourage the institutions with which
12 they are affiliated to:

13

14 (h) Be mindful of the messages the institution conveys within and outside its walls by how it
15 responds to prejudiced behavior by patients.

16

17 (i) Promote a safe and respectful working environment and formally set clear expectations for
18 how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

19

20 (j) Clearly and openly support physicians, trainees, and facility personnel who experience
21 prejudiced behavior and discrimination by patients.

22

23 (k) Collect data regarding incidents of discrimination by patients and their effects on
24 physicians and facility personnel on an ongoing basis and seek to improve how incidents
25 are addressed to better meet the needs of patients, physicians, other facility personnel, and
26 the community.

27

28 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. *JAMA Network Open*. 2018;1(5):e182723.
2. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. *Acad. Med.* 2016;91:S64–S69.
3. Fnais N, Soobiah C, Hong Chen M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med.* 2014;89:817–827.
4. Paul-Emile K. Patients Racial Preferences and the Medical Culture of Accommodation. *UCLA Law Rev.* 2012;60:462–504.
5. Reddy S. How doctors deal with racist patients. *The Wall Street Journal*. <https://www.wsj.com/articles/how-doctors-deal-with-racist-patients-1516633710>. Published January 22, 2018. Accessed July 23, 2019.
6. Novick DR. Racist Patients Often Leave Doctors at a Loss. *Washington Post*. http://wapo.st/2inREoW?tid=ss_mail&utm_term=.778203357cdf. Published October 19, 2017. Accessed July 23, 2019.
7. Haelle T. Physician guidance for dealing with racist patients. *Medscape*. <https://www.medscape.org/viewarticle/859354>. Published March 17, 2016. Accessed July 23, 2019.
8. Cajigal S, Scudder L. Patient prejudice: when credentials aren't enough. *Medscape*. Published October 18, 2017. Accessed July 23, 2019.
9. Rosoff PM. Discriminatory demands by patients. *Hastings Center Report*. 2018;48(4):7–11.
10. Price O, Baker J. Key components of de-escalation techniques: a thematic synthesis. *Intl J Mental Health Nursing*. 2012;21:310–319.
11. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17–25.
12. Malat J, Hamilton MA. Preference for same-race health care providers and perception of interpersonal discrimination in health care. *J. Health Social Behavior*. 2006;47(June):173–187.
13. Reynolds KL, Cowden JD, Brosco JP, Lantos JD. When a family requests a white doctor. *Pediatrics*. 2015;136(2):381–386.
14. Lepora C, Danis M, Wertheimer A. No Exceptionalism Needed to Treat Terrorists. *AJOB*. 2009;9(10):53–54.
15. American Medical Association *Code of Medical Ethics*. Principle I. Available at. <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Published 2017. Accessed July 23, 2019.
16. American Medical Association *Code of Medical Ethics*. Principle VI. Available at. <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Published 2017. Accessed July 23, 2019.
17. American Medical Association *Code of Medical Ethics*. Opinion 1.1.2 Prospective patients. Available at <https://policysearch.ama-assn.org/policyfinder/detail/1.1.2?uri=%2FAMADoc%2FEthics.xml-E-1.1.2.xml>. Published 2017. Accessed July 23, 2019.
18. American Medical Association *Code of Medical Ethics*. Opinion 1.2.2. Disruptive behavior by patients. Available at <https://policysearch.ama-assn.org/policyfinder/detail/transfer%20patient?uri=%2FAMADoc%2FEthics.xml-E-1.2.2.xml>. Published 2017. Accessed July 23, 2019.
19. Anstey K, Wright L. Responding to discriminatory requests for a different healthcare provider. *Nursing Ethics*. 2013;1–11.

20. McCruden P. Dealing with racist patient requests: law, rights, and Catholic identity. *Health Care Ethics USA*. 2017;Summer:21–29.
21. Jain SH. The racist patient. *Ann. Intern Med*. 2013;158:632.
22. Schmidt HG, van Gog T, CE Schuit S, et al. Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? a randomised experiment. *BMJ Quality & Safety*. 2017;26:19–23.
23. Mamede S, Van Gog T, Schuit SCE, et al. Why patients' disruptive behaviours impair diagnostic reasoning: a randomised experiment. *BMJ Quality & Safety*. 2017;26:13–18.
24. Lu DW, Dresden S, McCloskey C, Branzetti J, Gisondi MA. Impact of burnout on self-reported patient care among emergency physicians. *West J Emerg Med*. 2015;16(7):996–1001.
25. Dewa CS, Loong D, Bonato S, Trojanowski L. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open*. 2017;7:e01514.
26. Halbesleben JRB, Rathert, C. Lining physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Management Review*. 2008;33(1):29–39.
27. Warsame RM, Hayes SN. Mayo Clinic's 5-step policy for responding to bias incidents. *AMA Journal of Ethics*. 2019;21(6):E521–529.
28. Okwerekwu JA. The patient called me 'colored girl'. the senior doctor training me said nothing. *Stat*. <https://www.statnews.com/2016/04/11/racism-medical-education/>. Published April 11, 2016. Accessed July 23, 2019.
29. Castillo M. Detroit nurse claims hospital barred African American staff from caring for white child. *CBS News*. <https://www.cbsnews.com/news/detroit-nurse-claims-hospital-barred-african-american-staff-from-caring-for-white-child/>. Published February 19, 2013.
30. Penn State Health. Patient Rights Policy. *Penn State Health*. <https://hmc.pennstatehealth.org/documents/11396232/11459793/Patient+Rights+Policy+PC-33-HAM/b4f54eb1-7183-43cb-a606-640be66a84c8>. Published May 2018. Accessed July 23, 2019.
31. Massachusetts General Hospital. Patient Rights and Responsibilities. *Massachusetts General Hospital*. <https://www.massgeneral.org/advocacy/rights/default.aspx>. Published 2019. Accessed July 23, 2019.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-19)

Introduced by: Medical Student Section

Subject: Support for the Use of Psychiatric Advance Directives

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Nearly 10 million US adults live with serious mental illness, defined as a mental
2 illness that “result[s] in serious functional impairment” and “interferes with one or more major life
3 activities”¹⁻²; and
4
5 Whereas, A survey of 213 patients who previously received coercive psychiatric treatment found
6 that they would like to engage in advance planning to determine their preferences for future care
7 during psychiatric crises³; and
8
9 Whereas, A psychiatric advance directive is a legal document written by a competent individual
10 with a mental illness, specifying their treatment preferences and/or granting their medical power
11 of attorney to a surrogate during a future psychiatric crisis that impairs the individual’s capacity⁴⁻⁶;
12 and
13
14 Whereas, A psychiatric advance directive differs from generic advance directives due to the
15 unique nature of psychiatric illness and treatment⁵⁻⁷; and
16
17 Whereas, While most states enable psychiatric advance directive creation under broader
18 advance directive statutes, only 25 states have legislation pertaining specifically to the use of
19 psychiatric advance directives⁴⁻⁶; and
20
21 Whereas, In Nevada and New Hampshire, while a patient may designate an agent to make
22 healthcare decisions for them should they become incompetent, they may only specify in writing
23 advance instructions on non-psychiatric life-sustaining care⁴⁻⁶; and
24
25 Whereas, The Patient Self-Determination Act of 1990 states that Medicare and Medicaid
26 patients should be advised on opportunities to specify treatment preferences prior to the loss of
27 decision-making capacity when possible⁸; and
28
29 Whereas, The Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality
30 Reporting Program Manual specifies that a “patient should be allowed the opportunity to appoint
31 a surrogate decision maker or complete non-psychiatric and psychiatric advance directives”⁹;
32 and
33
34 Whereas, The use of psychiatric advance directives can help improve patient autonomy,
35 treatment adherence, and the physician-patient relationship and reduce the need for coercive
36 interventions such as involuntary commitment, seclusion, restraints, police transport, and
37 involuntary medications¹⁰⁻¹²; and

1 Whereas, In the first 6 months following psychiatric advance directive completion, 6.5 percent of
2 patients experienced a coherence crisis intervention compared to 19.7 percent of non-
3 completers¹⁰; and
4
5 Whereas, Patients with serious mental illness who participated in a facilitated psychiatric
6 advance directive completion session were 1.57 times more likely to experience an increase in
7 working alliance between themselves and clinicians after 1 month compared to patients who did
8 not experience the session¹¹; and
9
10 Whereas, Psychiatric advance directive completers were 7.8 times more likely to be adherent to
11 their psychiatric mediation after 1 year compared to non-completers¹²; and
12
13 Whereas, In the largest study of psychiatric advance directive usage to date, in over 1,000
14 patients with mental illness, only 7 percent of respondents had completed a psychiatric AD or
15 designated a surrogate for future psychiatric crises, while 68 percent of respondents expressed
16 interest in completing one¹³; and
17
18 Whereas, A survey of over 400 psychiatrists and psychologists showed that only 37 percent of
19 respondents demonstrated sufficient legal knowledge regarding psychiatric advance
20 directives¹⁴; and
21
22 Whereas, The use of facilitated psychiatric advance directive, an intervention in which a
23 psychiatric advance directive is completed by a patient with the assistance of a trained
24 individual, can reduce most barriers to psychiatric advance directive completion^{10,15}; and
25
26 Whereas, Low usage of psychiatric advance directive has led several states and organizations
27 to take steps to increase awareness and utilization of psychiatric advance directives, such as
28 establishing psychiatric advance directive completion clinics¹⁶⁻¹⁹; and
29
30 Whereas, Existing AMA policy “encourage[es] the use of advance directives and health care
31 powers of attorney” (H-140.845, Encouraging the Use of Advance Directives and Health Care
32 Powers of Attorney), “educating physicians about advance care planning” (H-85.956, Educating
33 Physicians About Advance Care Planning), and “promotes awareness and understanding of”
34 advance care planning in the unique situation of pregnancy (H-85.952, Advance Directives
35 During Pregnancy); and
36
37 Whereas, Similar to pregnant women, individuals with serious mental illness constitute a special
38 population with unique considerations that warrants additional attention in the area of advance
39 directive usage³⁻⁶; therefore be it
40
41 RESOLVED, That our American Medical Association support efforts to increase awareness and
42 appropriate utilization of psychiatric advance directives. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000

Received: 08/28/19

References:

1. Results from the 2015 National Survey on Drug Use and Health. US Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality. <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>. Published Sep 8, 2016. Accessed March 1st 2019.
2. Serious Mental Illness (SMI) Among US Adults. US National Institutes of Health (NIH) National Institute of Mental Health (NIMH). <https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml/index.shtml>. Published 2016. Accessed March 1st, 2019.
3. Krieger E, Moritz S, Weil R, Nagel M. Patients' attitudes towards and acceptance of coercion in psychiatry. *Psychiatry Res.* 2018;260:478-485.
4. About PADs. National Resource Center on Psychiatric Advance Directives (NRC-PAD). <https://www.nrc-pad.org>. Updated 2018. Accessed March 1st, 2019.
5. Frequently Asked Questions About Psychiatric Advance Directives. National Resource Center on Psychiatric Advance Directives (NRC-PAD). <https://www.nrc-pad.org/faqs>. Updated 2018. Accessed March 1st, 2019.
6. Psychiatric Advance Directives (PAD). National Alliance on Mental Illness (NAMI). [https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-\(PAD\)](https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD)). Updated 2019. Accessed March 1st, 2019.
7. Olsen DP. Ethically Relevant Differences in Advance Directives for Psychiatric and End-of-Life Care. *J Am Psychiatr Nurses Assoc.* 2016;22(1):52-59.
8. HR 5835 Omnibus Budget Reconciliation Act of 1990, Title IV, Section 4206. US Congress. <https://www.congress.gov/bill/101st-congress/house-bill/5835/text>. Published Nov 5, 1990.
9. Inpatient Psychiatric Facility Quality Reporting Program Manual. US Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS). https://www.qualityreportingcenter.com/wp-content/uploads/2017/12/IPF_ProgramManual_Version3.1_20171211_vFINAL508.pdf. Published Dec 2017. Accessed March 1st, 2019.
10. Swanson JW, Swartz MS, Elbogen EB, et al. Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions. *J Ment Health.* 2008;17(3):255-267.
11. Swanson JW, Swartz MS, Elbogen EB, et al. Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Serious Mental Illness. *Am J Psychiatry.* 2006;163:1943-1951.
12. Wilder CM, Elbogen EB, Moser LL, et al. Medication Preferences and Adherence Among Individuals with Severe Mental Illness and Psychiatric Advance Directives. *Psychiatr Serv.* 2010;61:380-385.
13. Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R. Psychiatric Advance Directives Among Public Mental Health Consumers in Five US Cities: Prevalence, Demand, and Correlates. *J Am Acad Psychiatr & Law.* 2006;34(1): 43-57.
14. Elbogen, EB, Swartz MS, Van Dorn R, Swanson JW, Kim M, Scheyett A. Clinical Decision Making and Views About Psychiatric Advance Directives. *Psychiatr Serv.* 2006;57(3):350-355.
15. Easter MM, Swanson JW, Robertson AG, Moser LL, Swartz MS. Facilitation of Psychiatric Advance Directives by Peers and Clinicians on Assertive Community Treatment Teams. *Psychiatry Serv.* 2017;68(7):717-723.
16. Kemp K, Zelle H, Bonnie RJ. Embedding Advance Directives in Routine Care for Persons with Serious Mental Illness: Implementation Challenges. *Psychiatr Serv.* 2015;66(1):10-14.
17. Zelle H, Kemp K, Bonnie RJ. Advance Directives for Mental Health Care: Innovation in Law, Policy, and Practice. *Psychiatry Serv.* 2015;66(1):7-9.
18. Olsen DP. Increasing the Use of Psychiatric Advance Directives. *Nurs Ethics.* 2017;24(3):265-267.
19. Psychiatric Advance Directives (PAD) Project. The University of Texas at Austin School of Law. <https://law.utexas.edu/probono/opportunities/psychiatric-advanced-directives-pad-project>. Published Sep 2017. Accessed March 1st, 2019.

RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to

encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Educating Physicians About Advance Care Planning H-85.956

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Advance Directives During Pregnancy H-85.952

1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.

Citation: (BOT Rep. 9, I-15)

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: (Res. 116, A-12; Reaffirmation A-15)

E-5.1 Advance Care Planning

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often

thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients' concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients' own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient's individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

- (a) Regularly encourage all patients, regardless of age or health status, to:
 - (i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);
 - (ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;
 - (iii) make their views known to their designated surrogate and to (other) family members or intimates.
- (b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.
- (c) Explain how advance directives, as written articulations of patients' preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate's responsibilities in decision making. Involve the patient's surrogate in this conversation whenever possible.
- (d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.
- (e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.

Issued: 2016

E-5.2 Advance Directives

Respect for autonomy and fidelity to the patient are widely acknowledged as core values in the professional ethics of medicine. For patients who lack decision-making capacity, these values are fulfilled through third-party decision making and the use of advance directives. Advance directives also support continuity of care for patients when they transition across care settings, physicians, or health care teams.

Advance directives, whether oral or written, advisory or a formal statutory document, are tools that give patients of all ages and health status the opportunity to express their values, goals for care, and treatment preferences to guide future decisions about health care. Advance directives also allow patients to identify whom they want to make decisions on their behalf when they cannot do so themselves. They enable physicians and surrogates to make good-faith efforts to respect the patient's goals and implement the patient's preferences when the patient does not have decision-making capacity.

An advance directive never takes precedence over the contemporaneous wishes of a patient who has decision-making capacity.

In emergency situations when a patient is not able to participate in treatment decisions and there is no surrogate or advance directive available to guide decisions, physicians should provide medically appropriate interventions when urgently needed to meet the patient's immediate clinical needs. Interventions may be withdrawn at a later time in keeping with the patient's preferences when they become known and in accordance with ethics guidance for withdrawing treatment.

Before initiating or continuing treatment, including, but not limited to, life-sustaining interventions, the physician should:

- (a) Assess the patient's decision-making capacity in the current clinical circumstances.
- (b) Ascertain whether the patient has an advance directive and if so, whether it accurately reflects his/her current values and preferences. Determine whether the patient's current clinical circumstances meet relevant thresholds set out in the directive.
- (c) Ascertain whether the patient has named a health care proxy (e.g., orally or through a formal legal document). If the patient has not, ask who the patient would want to have make decisions should he or she become unable to do so.
- (d) Document the conversation, including the patient's goals for care, and specific preferences regarding interventions and surrogate decision maker, in the medical record; incorporate any written directives (as available) into the medical record to ensure they are accessible to the health care team.
- (e) When treatment decisions must be made by the patient's surrogate, help the surrogate understand how to carry out the patient's wishes in keeping with the advance directive (when available), including whether the directive applies in the patient's current clinical circumstances and what medically appropriate interventions are available to achieve the patient's goals for care. When conflicts arise between the advance directive and the wishes of the patient's surrogate, the attending physician should seek assistance from an ethics committee or other appropriate institutional resource.
- (f) When a patient who lacks decision-making capacity has no advance directive and there is no surrogate available and willing to make treatment decisions on the patient's behalf, or no surrogate can be identified, the attending physician should seek assistance from an ethics committee or other appropriate resource in ascertaining the patient's best interest.
- (g) Document physician orders to implement treatment decisions in the medical record, including both orders for specific, ongoing interventions (e.g., palliative interventions) and orders to forgo specific interventions (e.g., orders not to attempt resuscitation, not to intubate, not to provide antibiotics or dialysis).

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-19)

Introduced by: Medical Student Section

Subject: Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, In 2016, the National Institute of Minority Health and Health Disparities, a division of
2 the National Institutes of Health (NIH), designated sexual and gender minorities a health
3 disparity population for research purposes¹; and
4
5 Whereas, The NIH established in 2015 a Sexual and Gender Minority (SGM) Research Office
6 and provides funding earmarked for SGM-specific medical research^{2,3}; and
7
8 Whereas, Pursuant to existing AMA policy H-160.991, our AMA believes in “educating
9 physicians on the current state of research in and knowledge of LGBTQ Health”; and
10
11 Whereas, The need for further research within LGBTQ communities is well established,
12 especially for vulnerable populations such as LGBTQ-identified youth and older adults⁴; and
13
14 Whereas, Novel peer-reviewed recommendations for ethical research with transgender
15 populations and best-practices for research processes such as sexual orientation and gender
16 identity (SOGI) data have been documented^{4, 5, 6, 7}; and
17
18 Whereas, Because of the patchwork legal protection afforded to LGBTQ populations, disclosure
19 of research participant SGM status through collection of SOGI data or LGBTQ research
20 affiliation can negatively impact participants’ livelihood^{8, 9}; and
21
22 Whereas, Prominent LGBTQ health organizations, such as Fenway Institute, GLMA: Health
23 Professionals Advancing LGBTQ Health Equality, World Professional Association for
24 Transgender Health, and the William’s Institute have not produced a standardized training
25 module on how to protect SOGI data and LGBTQ patient identity in research processes^{10, 11};
26 therefore be it
27
28 RESOLVED, That our American Medical Association work with appropriate stakeholders to
29 support the creation of model training for Institutional Review Boards to use and/or modify for
30 their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-
31 sexual, Transgender and Queer populations. (Directive to Take Action)

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

Received: 08/28/19

References:

1. NIMH and Health Disparities Director's Message October 6, 2016. https://www.nimhd.nih.gov/about/directors-corner/messages/message_10-06-16.html. Accessed April 15, 2019.
2. NIH Sexual and Gender Minority Research Office. <https://dpcpsi.nih.gov/sgmro>. Accessed April 15, 2019.
3. NIH Sexual and Gender Minority Research Office Funding Opportunities. <https://dpcpsi.nih.gov/sgmro/funding>. Accessed April 15, 2019.
4. Fisher CB, Mustanski B. Reducing Health Disparities and Enhancing the Responsible Conduct of Research Involving LGBT Youth. *Hastings Center Report*. 2014;44(s4). doi:10.1002/hast.367.
5. Cloyes KG. The Silence of Our Science: Nursing Research on LGBT Older Adult Health. *Research in Gerontological Nursing*. 2015;9(2):92-104. doi:10.3928/19404921-20151218-02.
6. Noah Adams, Ruth Pearce, Jamie Veale, Asa Radix, Danielle Castro, Amrita Sarkar, and Kai Cheng Thom. Transgender Health. Dec 2017. <http://doi.org/10.1089/trgh.2017.0012>
7. Donald C, Ehrenfeld JM. The Opportunity for Medical Systems to Reduce Health Disparities Among Lesbian, Gay, Bisexual, Transgender and Intersex Patients. *Journal of medical systems*. 2015;39(11):178.
8. Cahill SR, Baker K, Deutsch MB, Keatley J, Makadon HJ. Inclusion of Sexual Orientation and Gender Identity in Stage 3 Meaningful Use Guidelines: A Huge Step Forward for LGBT Health. *LGBT health*. 2016;3(2):100-102.
9. Siskind RL, Andrasik M, Karuna ST, et al. Engaging Transgender People in NIH-Funded HIV/AIDS Clinical Trials Research. *Journal of acquired immune deficiency syndromes (1999)*. 2016;72 Suppl 3:S243-247
10. National LGBT Health Education Center Learning Modules. <https://www.lgbthealtheducation.org/lgbt-education/learning-modules/>. Accessed April 15, 2019.
11. National LGBT Health Education Center Webinars. <https://www.lgbthealtheducation.org/lgbt-education/webinars/>. Accessed April 15, 2019.

RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-19)

Introduced by: Medical Student Section

Subject: Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Office of the National Coordinator for Health Information Technology (ONC) is
2 the principal federal entity coordinating the electronic exchange of health information¹; and
3
4 Whereas, The U.S. Census collects data based on racial self-identification as White, Black or
5 African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other
6 Pacific Islander²; and
7
8 Whereas, In addition to health disparities between racial and ethnic groups, health disparities
9 also exist within U.S. Census-defined racial and ethnic groups^{3,4}; and
10
11 Whereas, Disaggregating racial and ethnic data is defined for the purpose of this resolution as
12 subdividing U.S. Census-defined racial or ethnic (i.e. Hispanic and non-Hispanic) designations
13 into ethnic subgroups (i.e. by splitting “Asian” into Vietnamese, Chinese, Japanese, Laotian,
14 Burmese, Pakistani, Indian, etc.)⁴; and
15
16 Whereas, A series of systematic literature reviews reported to the Robert Wood Johnson
17 Foundation identified that within-group disparities were more accurately accounted for by
18 research methodologies that used disaggregated racial and ethnic data among American
19 Indian/Alaska Native (AIAN); Asian American, Native Hawaiian, and Pacific Islander (AANHPI);
20 Latinx; non-Hispanic White Americans; and Black/African American populations⁴; and
21
22 Whereas, Despite being classified as White by the U.S. Census and other registries, several
23 population-level disparities exist between Arab Americans and other White ethnic groups⁵; and
24
25 Whereas, Health behaviors, such as dietary practices, vary within Asian and Latino subgroups
26 and thus require different interventions and may lead to different health outcomes^{6,7}; and
27
28 Whereas, Accurate preferred language data can help identify “hot-spot” geographic areas with a
29 high density of morbidity and could facilitate addressing social determinants of health⁸; and
30
31 Whereas, A 2017 randomized controlled trial and retrospective study at an inner-city pain clinic
32 demonstrated improved adherence to treatment and attendance at scheduled appointments
33 after an intervention was deployed that utilized accurate preferred language data^{9,10}; and
34
35 Whereas, Race, ethnicity, and language (REL) and other socio-demographic data could be
36 used to identify targeted interventions for high-risk patients or areas for quality improvement^{11,12};
37 and

1 Whereas, Despite recognition that such data can improve care, reliable collection of REL is
2 uncommon, even in settings that treat large minority and immigrant populations^{8,11-13}; and
3
4 Whereas, Several successful systems-level interventions with evidence of improved screening
5 for accurate REL data have been published to date^{12,14}; and
6
7 Whereas, Existing guidelines for electronic health record (EHR) collection of REL data have led
8 to inaccuracies that could reduce the effectiveness of interventions based on this data¹³; and
9
10 Whereas, Our AMA has supported reducing racial and ethnic disparities in health care by
11 studying health system opportunities and barriers to eliminating disparities (D-350.995); and
12
13 Whereas, Our AMA has advocated for precision in racial, ethnic, and religious designations in
14 medical records, but has not done so for preferred language (H-315.996); and
15
16 Whereas, Our AMA has supported the collection of disaggregated racial data, but current policy
17 lacks actionable language to engage stakeholders (H-350.954); therefore be it
18
19 RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to
20 read as follows:
21

22 **Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical
23 Records, H-315.996**

24 The AMA advocates precision in racial, ethnic, preferred language, and religious
25 designations in medical records, with information obtained from the patient, always
26 respecting the personal privacy of the patient (Modify Current HOD Policy); and be it
27 further

28
29 RESOLVED, That our AMA encourage the Office of the National Coordinator for Health
30 Information Technology (ONC) to expand their data collection requirements, such that electronic
31 health record (EHR) vendors include options for disaggregated coding of race and ethnicity.
32 (Directive to Take Action)

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

Received: 08/28/19

References:

1. About ONC. <https://www.healthit.gov/topic/about-onc>. Accessed March 17, 2019.
2. Bureau UC. About Race. <https://www.census.gov/topics/population/race/about.html>. Accessed March 12, 2019.
3. Can Capturing More Detailed Data Advance Health Equity? RWJF. <https://www.rwjf.org/en/blog/2018/08/can-capturing-more-detailed-data-advance-health-equity.html>. Published August 30, 2018. Accessed March 12, 2019.
4. Making the Case for Data Disaggregation to Advance a Culture of Health. <http://www.policylink.org/our-work/community/health-equity/data-disaggregation>. Accessed March 12, 2019.
5. Abuelezam NN, El-Sayed AM, Galea S. The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review. *Front Public Health*. 2018;6. doi:10.3389/fpubh.2018.00262
6. Crawford MA, Mendoza-Vasconez AS, Larsen BA. Type II diabetes disparities in diverse women: the potential roles of body composition, diet and physical activity. *Womens Health Lond Engl*. 2015;11(6):913-927. doi:10.2217/whe.15.62
7. Guerrero AD, Ponce NA, Chung PJ. Obesogenic Dietary Practices of Latino and Asian Subgroups of Children in California: An Analysis of the California Health Interview Survey, 2007-2012. *Am J Public Health*. 2015;105(8):e105-112. doi:10.2105/AJPH.2015.302618
8. Chin MH. Using Patient Race, Ethnicity, and Language Data to Achieve Health Equity. *J Gen Intern Med*. 2015;30(6):703-705. doi:10.1007/s11606-015-3245-2
9. Andreae MH, Nair S, Gabry JS, Goodrich B, Hall C, Shaparin N. A pragmatic trial to improve adherence with scheduled appointments in an inner-city pain clinic by human phone calls in the patient's preferred language. *J Clin Anesth*. 2017;42:77-83. doi:10.1016/j.jclinane.2017.08.014
10. Andreae MH, White RS, Chen KY, Nair S, Hall C, Shaparin N. The Effect of Initiatives to Overcome Language Barriers and Improve Attendance: A Cross-Sectional Analysis of Adherence in an Inner City Chronic Pain Clinic. *Pain Med Malden Mass*.

2017;18(2):265-274. doi:10.1093/pnw161

11. Cook SC, Goddu AP, Clarke AR, Nocon RS, McCullough KW, Chin MH. Lessons for Reducing Disparities in Regional Quality Improvement Efforts. *Am J Manag Care*. 2012;18(6 0):s102.
12. Ramos R, Davis JL, Ross T, Grant CG, Green BL. Measuring health disparities and health inequities: do you have REGAL data? *Qual Manag Health Care*. 2012;21(3):176-187. doi:10.1097/QMH.0b013e31825e8889
13. Klinger EV, Carlini SV, Gonzalez I, et al. Accuracy of race, ethnicity, and language preference in an electronic health record. *J Gen Intern Med*. 2015;30(6):719-723. doi:10.1007/s11606-014-3102-8
14. Standiford CJ, Nolan E, Harris M, Bernstein SJ. Improving the provision of language services at an academic medical center: ensuring high-quality health communication for limited-English-proficient patients. *Acad Med J Assoc Am Med Coll*. 2009;84(12):1693-1697. doi:10.1097/ACM.0b013e3181bf4659

RELEVANT AMA POLICY:

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17; Appended: Res. 403, A-19

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19;

Hospital Surveys and Health Care Disparities H-450.924

1. Our AMA supports that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care.
2. Our AMA recognizes the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings.
3. Our AMA supports that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities.
4. Our AMA will continue to advocate for better risk models that account for social risk factors in hospital quality program assessments.
5. Our AMA will continue to work with CMS and other stakeholders, including representatives of Americas Essential Hospitals, to address issues related to hospital quality program assessments.
6. Our AMA opposes hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals.

Citation: CMS Rep. 02, I-17; Reaffirmed: CMS Rep. 10, A-19

Sharing Demographic Medicare Data with Other Public Entities by CMS H-330.934

The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.

Citation: Sub. Res. 810, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Accuracy in Racial, Ethnic and Religious Designations in Medical Records H-315.996

The AMA advocates precision in racial, ethnic and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient. Citation: (Res. 4, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15)

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and

(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-19)

Introduced by: Medical Student Section

Subject: Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Approximately 1.4 million individuals in the United States identify as transgender¹;
2 and
3
4 Whereas, 39% of transgender individuals reported experiencing serious psychological distress
5 and 40% reported having attempted suicide in their lifetime³; and
6
7 Whereas, 33% of transgender individuals in a survey identified having at least one negative
8 experience with their healthcare provider in the last year³; and
9
10 Whereas, 28% of transgender individuals reported postponing needed medical care due to fear
11 of discrimination, which contributes to the significant health disparities they experience⁴; and
12
13 Whereas, A majority of transgender men prefer self-sampling, self-collecting vaginal or cervical
14 samples at home, to screen for cervical cancer versus provider-administered Pap smear⁵; and
15
16 Whereas, Only 49.5% of transgender men have had a Pap smear screening within the past 3
17 years and 31.9% of transgender men have never had Pap smear screening⁵; and
18
19 Whereas, Individuals in a study who classified their gender expression as “female” and sex as
20 male were significantly more likely to have routine Pap testing compared with individuals who
21 identified as “transgender,” suggesting a discrepancy in Pap smears provided to cisgender
22 women versus transgender individuals⁶; and
23
24 Whereas, Transgender individuals may often require specific screenings and considerations,
25 particularly if they have past or current usage of hormone therapy, such as monitoring for
26 diabetes mellitus in transgender women, as they have an increased risk for development of
27 diabetes mellitus while on estrogen therapy⁷; and
28
29 Whereas, In a transgender woman with an intact prostate, it is recommended to regularly
30 screen for prostate cancer⁷; and
31
32 Whereas, The World Professional Association for Transgender Health (WPATH) states that sex-
33 specific organ procedures and diagnoses relating to organs such as the penis, testes, vagina,
34 prostate, uterus, etc., should be un-coupled, so that “(as an example) a prostatic ultrasound
35 may be ordered on a patient registered as female, or a cervical pap smear ordered on a patient
36 registered as male”⁹; and

1 Whereas, The US General Accountability Office's Health Information Technology (HIT) Policy
2 Committee recommended the inclusion of gender ID data in electronic medical records (EMR)
3 and recent research demonstrates current proposed Systematized Nomenclature in Medicine
4 (SNOMED) codes do not reflect these recommendations ^{9,10}; and
5
6 Whereas, The World Professional Association for Transgender Health (WPATH) executive
7 committee in 2011 recommended demographic variables in EMR include assigned sex at birth,
8 gender identity, and pronoun preference, but these practices remain uncommon in the United
9 States ¹¹; and
10
11 Whereas, In a study to determine the extent to which patients' notes in EMR contained
12 transgender-related terms, where ICD codes specific to transgender experience could be
13 verified as a transgender experience could be verified as a transgender patient's using free text
14 searches in the note, 89.3% of patients defined as transgender were identified with transgender-
15 preferred terms^{12,14}; and
16
17 Whereas, It was found that diagnostic codes alone were not a significantly sensitive identifier or
18 transgender charts, supporting the need for increased demographic and organ inventory data¹⁵;
19 and
20
21 Whereas, Pap smears may be traumatic for transgender patients, and EMR indicating
22 transgender identity and related history can allow the physician and healthcare team to properly
23 care for the individual during a pap smear⁷; and
24
25 Whereas, Research shows mis-gendering and misclassification are psychologically disruptive
26 and are associated with negative affect, negative impact on mental health, and transgender-felt
27 stigma ¹³; and
28
29 Whereas, The above data indicates that EMR can have a negative impact on the mental health
30 of transgender individuals due to mis-gendering from EMR that is not fully inclusive of
31 transgender patients; and
32
33 Whereas, Based on data stated above, discrepancies in EMR system may contribute to poor
34 health outcomes in transgender individuals; and
35
36 Whereas, The World Professional Association for Transgender Health (WPATH) strongly
37 recommends including "preferred name, gender identity, and pronoun preference, as identified
38 by patients," to be included as demographic variables, along with providing a "means to
39 maintain an inventory of a patient's medical transition history and current anatomy" ⁹; and
40
41 Whereas, Our AMA believes that the physician's recognition of patients' sexual orientations,
42 sexual behaviors, and gender identities without judgement or bias optimizes patient care in
43 health as well as in illness, and that this recognition is especially important in addressing the
44 specific health care needs of people who are or may be LGBTQ (AMA Policy H.160.991);
45 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-315.967, "Promoting
2 Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition
3 and deletion to read as follows:

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

6 Our AMA: (1) supports the voluntary inclusion of a patient's biological sex,
7 current gender identity, sexual orientation, and preferred gender pronoun(s),
8 preferred name, and an inventory of current anatomy in medical documentation
9 and related forms, including in electronic health records, in a culturally-sensitive
10 and voluntary manner and (2) will advocate for collection of patient data in
11 medical documentation and in medical research studies, according to current
12 best practices, that is inclusive of sexual orientation, gender identity, and other
13 sexual and gender minority traits for the purposes of research into patient and
14 population health; (3) will research the problems related to the handling of sex
15 and gender within health information technology (HIT) products and how to best
16 work with vendors so their HIT products treat patients equally and appropriately,
17 regardless of sexual or gender identity; (4) will investigate the use of personal
18 health records to reduce physician burden in maintaining accurate patient
19 information instead of having to query each patient regarding sexual orientation
20 and gender identity at each encounter; and (5) will advocate for the incorporation
21 of recommended best practices into electronic health records and other HIT
22 products at no additional cost to physicians. (Modify Current HOD Policy)

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

Received: 08/28/19

References:

1. Flores AR, Herman JL, Gates GJ, Brown TNT. "How many adults identify as transgender in the United States." *The Williams Institute UCLA School of Law*; June 2016.
2. Choi SK, Meyer IH. "LGBT aging: a review of research findings, needs, and policy implications." *The William Institute UCLA School of Law*; August 2016.
3. James S, et al. "The Report of the 2015 U.S. Transgender Survey." *National Center for Transgender Equality*, Washington, DC; 2015.
4. Seelman KL, et al. "Transgender noninclusive healthcare and delaying care because of fear: connections to general health and mental health among transgender adults." *Transgend Health*, 2017; 2:17-28.
5. Buys SS, et al. "Effect of screening on ovarian cancer mortality: the Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening randomized controlled trial." *JAMA*, 2011; 305:2295-2303.
6. Gatos, KC. "A Literature Review of Cervical Cancer Screening in Transgender Men." *Nursing for Women's Health*, 2018 Feb; 22(1):52-62.
7. Feldman J, Deutsch M. "Primary care of transgender individuals." 2018 Oct.
8. Collier, R. "National Physician Survey: EMR use at 75%." *Canadian Medical Association Journal*, 2015 Jan; 187(4):E17-E18.
9. Deutsch, MB, et al. "Electronic Medical Records and the Transgender Patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group." *Journal of the American Medical Informatics Association*, 2013 Apr; 20(4):700-703.
10. Cahill S, Makadon HJ. "Sexual orientation and gender identity data collection update: U.S. Government takes steps to promote sexual orientation and gender identity data collection through Meaningful Use guidelines." *LGBT Health*. 2014;1(3):157-160.
11. Gupta, et al. "Challenges in Transgender Healthcare: The Pathology Perspective." *Lab Med*. 2016 Aug; 47(3), pp. 180-188.
12. Blosnich, J R, et al. "Using Clinician Text Notes in Electronic Medical Record Data to Validate Transgender-Related Diagnosis Codes." *J Am Med Inform Assoc*. 2018 Jul; 25(7), pp. 905-908.
13. McLemore, K. "Experiences with Misgendering: Identity Misclassification of Transgender Spectrum Individuals." *Self and Identity*. 2014; 14.
14. Proctor, K., et al. "Identifying the Transgender Population in the Medicare Program." *Transgend Health*. 2016; 1(1): 250-265.
15. Roblin, D., et al. "A novel method for estimating transgender status using electronic medical records." *Ann Epidemiol*. 2016; 26(3): 198-203.

RELEVANT AMA POLICY:

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations

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

H-65.967 Conforming birth certificate policies to current medical standards for transgender patients

1. Our AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.

Citation: Res. 4, A-13; Appended: BOT Rep. 26, A-14; Modified: Res. 003, A-19

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

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

Citation: Res. 014, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-19)

Introduced by: Medical Student Section

Subject: Removing Sex Designation from the Public Portion of the Birth Certificate

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Our AMA believes that the physician's nonjudgmental recognition of patients' gender
2 identities enhances the ability to render optimal patient care (H-160.991) and opposes any
3 efforts to deny an individual's right to determine their stated sex marker or gender identity
4 (H-65.962); and

5 Whereas, The legal sex designated on the public "upper portion" of a birth certificate by a
6 physician is typically based solely on an external evaluation and if sex cannot be determined it
7 is left blank with no entry; sex is also not recorded on the private "lower portion" of the birth
8 certificate where vital medical data is recorded and reported to public health officials¹⁻³; and

10 Whereas, The certificate of live birth draws on the information contained in the medical record
11 but is solely a legal document and is not used for patient care^{3,4}; and

13 Whereas, Analysis of data from 1955-2000 found that up to 1.7% of births in countries including
14 the US, Europe, and to a lesser extent Asia and Africa, deviate in some way from binary sex
15 designation, and therefore are categorized incorrectly as male or female on their birth
16 certificate⁵; and

18 Whereas, Only 9% of transgender people who want to change the sex designation on their birth
19 certificate actually do so, and 32% of transgender people with an ID who wanted to change the
20 sex did not do so due to cost⁶⁻⁸; and

22 Whereas, The National Transgender Discrimination Survey found only 24% of transgender
23 people were able to correct the gender marker on their birth certificates, 18% were denied the
24 correction, and 53% had not attempted correction⁸; and

26 Whereas, A national survey of transgender individuals showed 32% of transgender people were
27 harassed, asked to leave an establishment, or assaulted due to presenting identification that did
28 not match their gender presentation, and 13% were denied coverage for medical services
29 considered to be gender-specific, including routine sexual or reproductive health screenings
30 such as Pap smears, prostate exams, and mammograms^{7,8}; and

32 Whereas, The process of changing the sex designation on a birth certificate is complex and
33 typically requires legal counsel, adding additional cost and a necessary education level that
34 further disenfranchises the most vulnerable of transgender and intersex people⁸; and

36 Whereas, "Sexual and gender identity are characterized by fluidity and change," and individuals
37 can and do identify as genders other than male, female, or other, and would not be aided by
38 adding a third catch-all gender or sex category to the birth certificate⁹; and

1 Whereas, The German Constitutional Court recently ruled gender markers may be omitted from
2 birth certificates in children who cannot be assigned to a binary male/female sex, and similar
3 legislation is being considered in Malta and California¹⁰; therefore be it
4
5 RESOLVED, That our American Medical Association advocate for the removal of sex as a legal
6 designation on the public portion of the birth certificate and that it be visible for medical and
7 statistical use only. (Directive to Take Action)

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

Received: 08/28/19

References:

1. Conron, KJ et al 2014. "Sex and gender in the US health surveillance system: A call to action." *Am J Pub Health*.
2. "Hospital's and Physicians' Handbook on Birth Registration and Fetal Death Reporting" U.S. Department of Health and Human Services: Public Health Service National Center for Health Statistics. Hyattsville, Maryland October 1987. https://www.cdc.gov/nchs/data/misc/hb_birth.pdf
3. US Centers for Disease Control. "US Standard Certificate of Live Birth."
4. Brumberg, H. L., D. Dozor and S. G. Golombok (2012). "History of the birth certificate: from inception to the future of electronic data." *Journal Of Perinatology* 32: 407.
5. Blackless, M et al. 2000. "How sexually dimorphic are we? Review and synthesis." *American Journal of Human Biology*.
6. Superior Court of California, Statewide Civil Fees Schedule. No. 4: "Petition for a decree of change of name or gender"
7. Grant et al 2011 "Injustice at every turn: A report of the transgender discrimination survey. National Center for Transgender Equality and National Gay and Lesbian Task Force.
8. 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.
9. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhamer H, Landers S. "Sexual and gender minority health: what we know and what needs to be done." *Am J Public Health*. 2008;98(6):989–995. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2377288/>
10. BVerfG, Order of the First Senate of 10 October 2017 – 1 BvR 2019/16 – paras. (1-69) http://www.bverfg.de/e/rs20171010_1bvr201916en.html

RELEVANT AMA POLICY:

Affirming the Medical Spectrum of Gender H-65.962

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Citation: Res. 005, I-18

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) Encourages members to 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; (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 every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation

on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.
Citation: Res. 4, A-13; Appended: BOT Rep. 26, A-14; Modified: Res. 003, A-19

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 and Transgender Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, 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

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 one's 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 one's 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 prisoner's 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: 006
(I-19)

Introduced by: Medical Student Section

Subject: Transparency Improving Informed Consent for Reproductive Health Services

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Federal regulations passed by Health and Human Services in 2018 and state laws
2 allow organizations to refuse coverage and services for contraceptives and infertility care
3 mandated in the Affordable Care Act^{1,2}; and

4
5 Whereas, Institutional obligations under those refusals impinge on a physician's ability to follow
6 standard of care in consulting and providing reproductive health services³; and

7
8 Whereas, American College of Obstetricians and Gynecology (ACOG) guidelines state that
9 physicians are obligated to inform patients of their prior personal moral commitments and refer
10 patients to other providers in cases of moral or religious objection for management, medication,
11 or surgical evacuation^{4,5}; and

12
13 Whereas, The American Medical Association advocates for transparency when best practice
14 medical care may conflict with a physician's or their institution's commitments;⁷ which is not
15 currently occurring according to a recent national survey of obstetricians and gynecologists
16 showing that 35% of non-abortion providers would not provide a referral to a different institution
17 for the service⁷; and

18
19 Whereas, Reproductive healthcare access is vital to the health and well-being of both the
20 mother and her child given that mis-timed pregnancies are associated with poor or delayed
21 prenatal care, negative birth outcomes, Sexually Transmitted Infections (STIs) and cervical
22 cancer of the mother^{8,9}; and

23
24 Whereas, Contraceptive care has applications beyond family planning: improving patient safety
25 when given in conjunction with teratogenic medications, protecting women who have significant
26 likelihood of mortality with pregnancy, or during teratogenic disease outbreaks like the 2016
27 Zika Virus^{10, 11}; and

28
29 Whereas, Emergency contraception is widely utilized as 28.4% of women of reproductive age in
30 the United States have used emergency contraceptives¹²; and

31
32 Whereas, Public expenditures on family planning services save seven dollars on future
33 expenditures for each dollar spent on these measures by reducing the incidence of preterm and
34 low birth weight births, STIs, infertility, and cervical cancer¹³; and

35
36 Whereas, Infertility services including In-Vitro Fertilization (IVF) and ova/sperm retrieval service
37 availability varies significantly between states, insurance policies, and hospital systems¹⁴; and

1 Whereas, Studies have shown patients are “in dire need of positive rights to information about
2 and services to avoid the potential gap in care” which non-transparent clinical policies present,⁹
3 similar to the Medicare overhauls currently underway for price transparency¹⁵; therefore be it
4

5 RESOLVED, That our American Medical Association work with relevant stakeholders to
6 establish a list of Essential Reproductive Health Services (Directive to Take Action); and be it
7 further

8 RESOLVED, That our AMA advocate for legislation requiring healthcare organizations to clearly
9 publish online and in points of service which Essential Reproductive Health Services are
10 available at the organization along with any restrictions on Essential Reproductive Health
11 Services at the institution, and include referral information to patients of other providers that
12 cover the services within the same coverage area. (Directive to Take Action)

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

Received: 08/28/19

References:

1. “Insurance Coverage of Contraceptives.” *Guttmacher Institute*, 2 Jan. 2019, www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives?fbclid=IwAR3sA3yCGJ2o785GHd4SIL6WRj7ew-6eG68kNhILeAOaBRdO_7Uklihrtg.
2. U.S. Department of Health and Human Services. “Fact Sheet: Final Rules on Religious and Moral Exemptions and Accommodation for Coverage of Certain Preventive Services Under the Affordable Care Act.” *HHS.gov*, US Department of Health and Human Services, 7 Nov. 2018, www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html?fbclid=IwAR369PitAJh4RZDf25oxmVM-eWG-dwAS9ugxu4LQMniAFjpv7KuYPmWXEc.
3. Gordon, Mara. “For Doctors Who Want To Provide Abortions, Employment Contracts Often Tie Their Hands.” *NPR*, NPR, 26 Nov. 2018, www.npr.org/sections/health-shots/2018/11/26/668347657/for-doctors-who-want-to-provide-abortions-employment-contracts-often-tie-their-h.
4. “Women’s Health Care Physicians.” *Group B Strep and Pregnancy - ACOG*, www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine.
5. Early pregnancy loss. ACOG Practice bulletin no. 150. *Obstet Gynecol* 2015; 125: pp. 1258-1267
6. Morris, Jane, and Kavita Shah Arora. “Should Clinicians Challenge Faith-Based Institutional Values Conflicting with Their Own?” *Journal of Ethics | American Medical Association*, American Medical Association, 1 July 2018, journalofethics.ama-assn.org/article/should-clinicians-challenge-faith-based-institutional-values-conflicting-their-own/2018-07.
7. Estimating abortion provision and abortion referrals among United States Obstetrician-gynecologists in private practice. Desai, Sheila et al. *Contraception* , Volume 97 , Issue 4 , 297 - 302
8. Kost, Kathryn, et al. “Pregnancy Intentions, Maternal Behaviors, and Infant Health: Investigating Relationships With New Measures and Propensity Score Analysis” *Demography*. 2015;52(1):83-11. doi:10.1007/s13524-014-0359-9
9. Frost, J J, et al. “Return on Investment: a Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program.” *Current Neurology and Neuroscience Reports.*, U.S. National Library of Medicine, Dec. 2014, www.ncbi.nlm.nih.gov/pubmed/25314928.
10. Andreoli L, Bertsias G, Agmon-Levin N, Brown S, Cervera R, Costedoat-Chalumeau N, et al. EULAR recommendations for women’s health and the management of family planning, assisted reproduction, pregnancy and menopause in patients with systemic lupus erythematosus and/or antiphospholipid syndrome. *Annals of the Rheumatic Diseases*. 2017; 76:476-85.
11. Lathrop E, Romero L, Hurst S, Bracero N, Zapata LB, Frey MT, et al. The Zika Contraception Access Network: a feasibility programme to increase access to contraception in Puerto Rico during the 2016–17 Zika virus outbreak. *The Lancet Public Health*. 2018; 3:e91-e9.
12. Heller, Caroline, et al. “Emergency Contraception Use: The Influence of Awareness, Attitudes, and Beliefs Among Non-Hispanic White, Non-Hispanic Black, and Hispanic Women in the United States.” *Women’s Health Issues*, vol. 29, no. 2, 2019, pp. 161–169., doi:10.1016/j.whi.2019.01.003.
13. “You Have the Right to Know the Price.” *CMS.gov Centers for Medicare & Medicaid Services*, CMS, 27 Nov. 2018, www.cms.gov/blog/you-have-right-know-price.
14. Thompson, Charis. “IVF Global Histories, USA: between Rock and a Marketplace.” *Reproductive Biomedicine & Society Online*, vol. 2, 2016, pp. 128–135., doi:10.1016/j.rbms.2016.09.003.
15. “Learning from Experience: Where Religious Liberty Meets Reproductive Rights.” *Guttmacher Institute*, 18 Sept. 2018, www.guttmacher.org/gpr/2016/learning-experience-where-religious-liberty-meets-reproductive-rights.

RELEVANT AMA POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further

2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.

Citation: (Res. 7, I-11)

Access to Emergency Contraception D-75.997

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).
2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: CMS Rep. 1, A-00; Appended: Res. 506, A-07; Reaffirmed: CMS Rep. 01, A-17;

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

- a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
- b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
- c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
- d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
 - (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
 - (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
- e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

- a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
 - iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

- a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
- b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984

- 1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.

2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.

Citation: Res. 101, A-16

Abortion H-5.995

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Citation: (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Policy on Abortion H-5.990

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

Citation: Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19

Increasing Transparency of Hospital Contracts for Clinical and Non-Clinical Services H-215.963

1. Our AMA encourage hospitals to publicly disclose the following parameters of their contracts for the delivery of clinical and non-clinical services:

- (a) The entity with which the hospital has contracted;
- (b) The ownership of the entity with which the hospital has contracted;
- (c) What services are being provided in accordance with the contract;
- (d) Which entity owners, if any, serve on any of the hospital's boards or its affiliates' boards; and
- (e) Whether the hospital requires exclusive physician referrals to hospital subsidiaries for services.

2. AMA policy is that the organized medical staffs have an opportunity to be involved in the selection of clinical and non-clinical service providers in hospitals with adherence to appropriate conflict of interest policies.

Citation: BOT Rep. 2, A-09; Reaffirmed: CMS Rep. 01, A-19

Price Transparency D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments. Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-19)

Introduced by: Medical Student Section

Subject: Addressing the Racial Pay Gap in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Civil Rights Act prohibits discrimination based on race, color, religion, sex, or
2 national origin¹; and

3
4 Whereas, The racial wage gap persists across the labor market in the United States, meaning
5 that people of color earn less than their white counterparts in the same professions, conducting
6 the same work, with the same education and experience²; and

7
8 Whereas, The Bureau of Labor Statistics reports that in 1979 black men earned 80% of what
9 white men earned, whereas in 2016 black men earned 70% of what white men earn, suggesting
10 a worsening of the racial pay gap³; and

11
12 Whereas, The American College of Physicians has shown that after controlling for age, sex,
13 race, hours worked, and state of residence, Black physicians made \$194,444 annually,
14 compared to \$228,585 for White physicians – a difference of \$34,141⁴; and

15
16 Whereas, Black male physicians earn substantially less than white male physicians after
17 adjustment for physician specialty practice characteristics, age, and hours worked; and black
18 female physicians earn even less than their black male counterpart with adjustments accounting
19 for characteristics of physician and practice⁵; and

20
21 Whereas, White female physicians made 19 percent and Black female physicians made 29
22 percent less than their white male counterparts after controlling for hours worked, years of
23 practice, practice ownership status, board certification status, IMG status, type of degree,
24 demographics of practice, and proportion of Medicare and Medicaid patients⁵; and

25
26 Whereas, Black male physicians are more likely to work in primary care and to treat Medicaid
27 patients compared with white male physicians, adjustment for these and other practice
28 characteristics, does not eliminate, or even significantly reduce, the estimated differences in
29 earnings⁵; and

30
31 Whereas, A study of 128 academic medical centers found that Black or Hispanic faculty
32 constituted only 5% of new academic hires and had significantly longer promotion timelines
33 when compared to their white counterparts, after factors such as gender, tenure status, degree,
34 and NIH award status were adjusted for. Underrepresented minority (URM) faculty were still
35 less likely to be promoted at all levels⁶; therefore be it

1 RESOLVED, That our American Medical Association support measures of racial pay awareness
2 and the specific challenges that minority physicians face in regards to equal pay financial
3 attainment (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA support efforts to increase the transparency and accountability of
6 physician earnings through establishing transparency measures, in which physicians can
7 access information including but not limited to the salaries and race of medical physicians. (New
8 HOD Policy)

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

Received: 08/28/19

References:

1. Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241 (1964)
2. Treadwell HM. Wages and Women in Health Care: The Race and Gender Gap. *Am J Public Health*. 2019;109(2):208–209. doi:10.2105/AJPH.2018.304866
3. Bureau of Labor Statistics <https://www.bls.gov/opub/mlr/2017/beyond-bls/the-unexplainable-growing-black-white-wage-gap.htm>
4. Grisham, Sarah. "MedscapePhysicianCompensationReport2017." Medscape. April 5, 2017. Accessed August 23, 2017. <http://www.medscape.com/slideshow/compensation-2017-overview-6008547#1>
5. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ*. 2016;353:i2923. [Differences in incomes of physicians in the United States by race and sex: observational study <https://www.bmjjournals.org/content/353/bmji2923>]
6. Nunez-smith M, Ciarleglio MM, Sandoval-schaefer T, et al. Institutional variation in the promotion of racial/ethnic minority faculty at US medical schools. *Am J Public Health*. 2012;102(5):852-8.

RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

1. Our AMA supports increasing the representation of minorities in the physician population by:
 - (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
 - (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
 - (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
 - (4) Increasing the supply of minority health professionals.
 - (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
 - (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
 - (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
 - (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
- (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
- (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
- (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
- (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
- (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
- (8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
- (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-19)

Introduced by: Jerry Halverson, MD; Shannon Kilgore, MD; Meridith Englander, MD; Hugh Taylor, MD; Steven Chen, MD; Adam Rubin, MD; David Tayloe, MD; Stuart Glassman, MD; Delegates

Subject: Data for Specialty Society Five-Year Review

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Policy G-600.020, "Admission of Specialty Organizations to our AMA House of
2 Delegates," establishes the guidelines for evaluating specialty society applications and five-year
3 review submissions; and
4
5 Whereas, The policy focuses on the physician membership of specialty societies and AMA
6 policy defines physicians as those possessing the degree of Doctor of Medicine or Doctor of
7 Osteopathy (Policies H-405.951, H-405.969 and D-405.991); and
8
9 Whereas, Specialty organizations establish their own rules determining who within their
10 membership will have full voting privileges and is eligible to hold office, allowing different
11 organizations to report different categories of members to the AMA for the five-year review
12 process thus impacting delegate apportionment under Bylaw 2.2 (G-600.027); and
13
14 Whereas, The requirement that an "organization must have a voluntary membership and must
15 report as members only those who are current in payment of dues, have full voting privileges,
16 and are eligible to hold office" is not always clear as to who should be counted and leads to
17 many inquiries, suggesting that societies are interpreting the requirement differently; and
18
19 Whereas, Most of the confusion of who can be counted by the AMA is around who can hold
20 office and what that means, and who can vote and what they can vote for/on; therefore be it
21
22 RESOLVED, That American Medical Association policy G-600.020, "Admission of Specialty
23 Organizations to our AMA House," item 6, be amended by addition and deletion to read as
24 follows:
25
26 The organization must have a voluntary membership and must report as
27 members only those physician members who are current in payment of
28 applicable dues, have full voting privileges, and eligible to serve on committees
29 or the governing body hold office. (Modify Current HOD Policy)

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

Received: 10/01/19

RELEVANT AMA POLICY

Admission of Specialty Organizations to our AMA House G-600.020

The following guidelines shall be utilized in evaluating specialty society applications for representation in our AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):(1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership; (2) The organization must: (a) represent a field of medicine that has recognized scientific validity; (b) not have board certification as its primary focus; and (c) not require membership in the specialty organization as a requisite for board certification; (3) The organization must meet one of the following criteria: (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; (4) The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application; (5) Physicians should comprise the majority of the voting membership of the organization; (6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office; (7) The organization must be active within its field of medicine and hold at least one meeting of its members per year; (8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states; (9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization; (10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

CLRPD Rep. A, A-87CLRPD Rep. D, I-90CLRPD Rep. B, I-91Modified: CLRPD Rep. 2, I-97Modfied: CLRPD Rep. 3, A-00Consolidated: CLRPD Rep. 3, I-01Reaffirmed: CLRPD Rep. 2, A-05BOT Rep. 6, I-08Modified: CCB/CLRPD Rep. 3, A-12Modified: BOT Rep. 1, I-12

Definition and Use of the Term Physician H-405.951

Our AMA: 1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. 2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above: a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician; b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician. 3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care. 4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider. 5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and

define the nature of their doctorate degree. 6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA. 7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Res. 214, A-19

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

CME Rep. 4-A-94, Reaffirmed by Sub. Res. 712, I-94, Reaffirmed and Modified: CME Rep. 2, A-04, Res. 846, I-08, Reaffirmed in lieu of Res. 235, A-09, Reaffirmed: Res. 821, I-09, Appended: BOT Rep. 9, I-09, Reaffirmed: BOT Rep. 9, I-11, Reaffirmation A-13, Reaffirmation A-15, Reaffirmed in lieu of: Res. 225, A-17, Reaffirmed: Res. 228, A-19.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. 2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Res. 846, I-08, Modified: BOT Rep. 9, I-09, Reaffirmed: Res. 218, A-12

National Medical Specialty Organizations. B-2.2

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of

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

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

2.2.1.1 **Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. **2.2.2** **Additional Delegate.** A specialty society that has adopted and implemented **bylaw** provisions requiring unified membership is entitled to one additional delegate. If during any calendar year the specialty society adopts **bylaw** provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the specialty society shall be entitled to the additional delegate. The specialty society shall retain the additional delegate only if the membership information recorded by the AMA as of each subsequent December 31 confirms that all of the specialty society's members are members of the AMA. **2.2.3** **Selection.** Each specialty society shall select and adjust the number of delegates to conform with the number of seats authorized under this **bylaw**. **2.2.4** **Certification.** The president or secretary of each specialty society shall certify to the AMA the delegates and alternate delegates from their respective societies. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

2.2.5 **Term.** Delegates from specialty societies shall be selected for 2-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion. **2.2.6** **Vacancies.** The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

Designation of Specialty Societies for Representation in the House of Delegates G-600.027

1. Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request. 2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process: (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof. (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year. (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies. (i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each,

to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates. (ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates. (iii) In the case of a tie, the previous year's data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate. 3. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

BOT Rep. 06, I-16, Modified: CLRPD Rep. 01, A-17, Modified: Speakers Rep., I-17, Modified: Speakers Rep., A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-19)

Introduced by: Michigan

Subject: Ban Conversion Therapy of LGBTQ Youth

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Conversion or reparative therapy is any individual or group therapy in inpatient or
2 outpatient settings that attempts to change an individual's sexual orientation; and

3
4 Whereas, It is estimated that 350,000 adolescents have undergone conversion therapy, and
5 that as many as 40,000 adolescents in the United States will undergo conversion therapy this
6 year; and

7
8 Whereas, Behavioral therapists have practiced aversion therapy by submitting patients to
9 physical harm such as electric shocks, nausea, vomiting, or paralysis, or encouraging the
10 patient to self-harm when they become aroused by the same sex; and

11
12 Whereas, Individuals who have undergone conversion therapy have subsequently experienced
13 adverse consequences including increased risk of suicide, poor self-esteem, depression and
14 social withdrawal and were more likely to develop impotence and sexual dysfunction; and

15
16 Whereas, Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are five times
17 more likely to attempt suicide compared to heterosexual youth; and

18
19 Whereas, The nation's leading professional medical, health, and mental health organizations do
20 not support efforts to change young people's sexual orientation through therapy and have raised
21 serious concerns about the potential harm from such efforts, according to a publication
22 endorsed by the American Academy of Pediatrics, American Association of School
23 Administrators, American Counseling Association, American Federation of Teachers, American
24 Psychological Association, American School Counselor Association, American School Health
25 Association, Interfaith Alliance Foundation, National Association of School Psychologists,
26 National Association of Secondary School Principals, National Association of Social Workers,
27 National Education Association, and School Social Work Association of America; and

28
29 Whereas, The original psychologist who published on the efficacy of conversion therapy has
30 since rejected their own research as flawed and acknowledges the damage they have done to
31 the LGBTQ community; and

32
33 Whereas, The American Psychiatric Association has called upon lawmakers to "ban the harmful
34 and discriminatory practice" of conversion therapy which the organization describes as "posing
35 a significant risk of harm" in addition to lacking credible evidence to support its efficacy or
36 safety; and

37
38 Whereas, The United Nations Human Rights Council, in an attempt to "prevent torture and ill-
39 treatment" of LGBTQ persons, condemns the use of conversion therapy practices; and

1 Whereas, Legal scholars have successfully argued that conversion therapy bans are supported
2 by constitutional law; and
3
4 Whereas, Eighteen states and the District of Columbia have passed laws prohibiting the use of
5 conversion therapy practices by licensed health care practitioners on minors; and
6
7 Whereas, Our American Medical Association has policy (H-160.991) opposing "the use of
8 "reparative" or "conversion" therapy for sexual orientation or gender identity," therefore be it
9
10 RESOLVED, That our American Medical Association advocate for federal legislation to ban
11 conversion therapy. (Directive to Take Action)

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

Received: 10/03/19

Sources:

1. Drescher J, et al. The growing regulation of conversion therapy. *Journal of Medical Regulation*. 2016;102(2):7-12.
2. Mallory C, Brown TNT, Conron KJ. Williams Institute, UCLA School of Law. *Conversion Therapy and LGBT Youth*. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Jan-2018.pdf>. Published January 2018. Accessed February 27, 2019.
3. Gross A. Church Accused of Planning a Conversion Therapy Workshop for LGBTQ Girls. *Detroit Free Press*. February 6, 2018. <https://www.freep.com/story/news/local/michigan/wayne/2018/02/06/downriver-church-accused-planning-workshop-lgbtq-girls-thats-been-likened-controversial-conversion-t/310931002/>. Accessed January 12, 2019.
4. American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. [online] Available at: <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf> [Accessed 11 Jan. 2019].
5. Haldeman DC. Therapeutic antidotes: helping gay and bisexual men recover from conversion therapies. *Journal of Gay & Lesbian Psychotherapy*. 2002;5(3-4):117-130.
6. McGeorge CR, Carlson TS, Toomey RB. An Exploration of Family Therapists Beliefs about the Ethics of Conversion Therapy: The Influence of Negative Beliefs and Clinical Competence With Lesbian, Gay, and Bisexual Clients. *Journal of Marital and Family Therapy*. 2013;41(1):42-56. doi:10.1111/jmft.12040.
7. Centers for Disease Control and Prevention. Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12 - United States and Selected Sites, 2015. *MMWR Surveill Summ*. 2016;65(9). <https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6509.pdf>. Published August 12, 2016. Accessed February 27, 2019.
8. Just the Facts Coalition. Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel. Washington, DC: American Psychological Association; 2008. <https://www.apa.org/pi/lgbt/resources/just-the-facts.pdf>. Accessed January 11, 2019.
9. Spritzer RL. Spitzer reassesses his 2003 study of reparative therapy of homosexuality. *Archives of Sexual Behavior*. 2012;41(4):757-757.
10. American Psychiatric Association. APA reiterates strong opposition to conversion therapy. Published November 15, 2018.
11. United Nations Human Rights Council. Discrimination and Violence Against Individuals Based on Their Sexual Orientation and Gender Identity: Report of the Office of the United Nations High Commissioner for Human Rights. A/HRC/29/23. <https://undocs.org/A/HRC/29/23>. Published May 4, 2015. Accessed February 27, 2019.
12. Cyphers CS. Banning sexual orientation therapy: constitutionally supported and socially necessary. *Journal of Legal Medicine*. 2014;35(4):539-550.
13. Conversion Therapy Laws. Movement Advancement Project website. www.lgbtmap.org/equality-maps/conversion_therapy. Updated February 26, 2019. Accessed October 2, 2019.

RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(I-19)

Introduced by: Michigan

Subject: End Child Marriage

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, With the adoption of the Convention on the Rights of the Child, the United Nations
2 defined a child as any person younger than 18; this definition has since been used to establish
3 quantifiable targets for international development including child marriage; and
4
5 Whereas, The United States Global Strategy to Empower Adolescent Girls, released in 2016 by
6 the State Department, states that marriage before age 18 is a “human rights abuse” that
7 produces devastating effect on a girl’s life; and
8
9 Whereas, Between 2000 and 2010 more than 167,000 children across 38 states were married,
10 mostly to men 18 or older while the remaining twelve states and the District of Columbia did not
11 track this information; and
12
13 Whereas, Child marriage in the United States is associated with a 23 percent greater risk of
14 disease onset, including heart attack, diabetes, cancer, and stroke; and
15
16 Whereas, Child marriage is associated with higher rates of sexually transmitted infections, early
17 pregnancies, divorce, and intimate partner violence than women married at 21; and
18
19 Whereas, Mothers around the world who are under the age of 18 have a 35 percent to 55
20 percent higher risk of delivering a preterm or low-birthweight infant than mothers older than 19
21 years; and
22
23 Whereas, Child marriage in the United States has been associated with significantly increased
24 risk of almost all psychiatric disorders; approximately 35 percent of women who were married as
25 children presented with psychiatric disorders and 53 percent had a lifetime history of psychiatric
26 illnesses; and
27
28 Whereas, The majority of marriages among immigrant children occur after their arrival to the
29 United States with only a minority being wed outside of the country; and
30
31 Whereas, Statutory rape charges when young girls become pregnant may be avoided and have
32 been motivation to encourage marriage between the offender and the girl; and
33
34 Whereas, Delaware was the first state in the United States to ban child marriage with no
35 exception based on the consideration that children under 18 are unable to file for divorce or
36 seek shelter at a domestic violence shelter if needed; therefore be it

1 RESOLVED, That our American Medical Association oppose the practice of child marriage
2 (New HOD Policy); and be it further
3
4 RESOLVED, That our AMA advocate for the passage of state and federal legislation to end the
5 practice of child marriage. (Directive to Take Action)

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

Received: 10/03/19

Sources:

1. Koski A, Heymann J. Child marriage in the united states: how common is the practice, and which children are at greatest risk? Perspectives on Sexual and Reproductive Health. 2018; 50(2):59-65.
2. U.S. Department of State. U.S Global Strategy to Empower Adolescent Girls. <https://www.state.gov/documents/organization/254904.pdf>. Published March 2016.
3. Reiss F. Why can 12-year-olds still get married in the United States? The Washington Post. February 10, 2017.
4. Shaffer C. Michigan legislature tackles child marriage. Michigan Radio. November 30, 2018.
5. Dupre ME, Meadows SO. Disaggregating the effects of marital trajectories on health. Journal of Family Issues. 2007; 28(5):623-652. <https://doi.org/10.1177/0192513X06296296>.
6. Strat YL, Dubertret C, Foll BL. Child marriage in the united states and its association with mental health in women. Pediatrics. 2011; 128(3):524-530. doi:10.1542/peds.2011-0961
7. United Nations Children's Fund. Ending Child Marriage: Progress and Prospects. https://www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf. 2014.
8. WORLD Policy Analysis Center. Assessing National Action on Protection from Child Marriage. https://www.worldpolicycenter.org/sites/default/files/WORLD_Fact_Sheet_Legal_Protection_Against_Child_Marriage_2015.pdf. March 2015.
9. Nour NM. Child marriage: a silent health and human rights issue. Reviews in Obstetrics & Gynecology. 2009; 2(1):51-56. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2672998/pdf/RIOG002001_0051.pdf.
10. Hamilton, VE. The age of marital capacity: reconsidering civil recognition of adolescent marriage. William & Mary Law School Scholarship Repository. 2012; 1430:1818-1862. <https://scholarship.law.wm.edu/facpubs/1430>.
11. Feleke B. Delaware becomes first US state to fully ban child marriage. CNN. May 12, 2018. <https://www.cnn.com/2018/05/12/us/delaware-child-marriage-ban/index.html>