Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

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**** contained in the Handbook Addendum***

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18, November 2020

Subject: Specialty Society Representation in the House of Delegates - Five-Year Review

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Charles J. Rainey, MD, JD, Chair)

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2020 American Medical Association (AMA) Annual Meeting and the 2020 Interim Meeting in compliance with the five-year review process established by the HOD in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed in anticipation of the 2020 Annual Meeting:

American Academy of Otolaryngic Allergy
American Association for Geriatric Psychiatry
American College of Legal Medicine
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Surgeons
American Society of Breast Surgeons
American Society of Retina Specialists
American Vein and Lymphatic Society
Heart Rhythm Society
International Academy of Independent Medical Evaluators
Society of Hospital Medicine
Undersea and Hyperbaric Medical Society

The following organizations were also reviewed in anticipation of the 2020 Annual Meeting, having failed to meet the requirements at the 2019 Annual Meeting:

American Society for Aesthetic Plastic Surgery

American Society of Interventional Pain Physicians
Association of University Radiologists
Infectious Diseases Society of America
International Society for the Advancement of Spine Surgery

The following organizations were reviewed in anticipation of the 2020 Interim Meeting:

American College of Occupational and Environmental Medicine
American Gastroenterological Association
American Geriatrics Society
American Orthopaedic Association
American Psychiatric Association
American Roentgen Ray Society
American Society of Abdominal Surgeons
The Triological Society

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicated that the American Society for Aesthetic Plastic Surgery and the International Academy of Independent Medical Examiners did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The American Society of Abdominal Surgeons did not submit materials and is therefore not in compliance.

RECOMMENDATIONS

In light of the cancellation of the 2020 Annual and Interim Meetings and with an intention to continue compliance with the five-year review process, the Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the International Academy of Independent Medical Evaluators and the American Society of Abdominal Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society for Aesthetic Plastic Surgery not retain representation in the House of Delegates. (Directive to Take Action)

Fiscal Note: Less than $500 to implement.

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Otolaryngic Allergy	259 of 997 (26%)
American Association for Geriatric Psychiatry	233 of 829 (28%0
American College of Legal Medicine	52 of 176 (30%)
American College of Mohs Surgery	306 of 1,088 (28%)
American College of Obstetrician and Gynecologists	13,123 of 43,410 (30%)
American College of Occupational and Environmental Medicine	646 of 2,633 (25%)
American College of Physicians	33,190 of 102,042 (32%)
American College of Preventive Medicine	326 of 1,193 (27%)
American College of Radiology	7.370 of 34,011 (22%)
American College of Surgeons	5,869 of 29,938 (20%)
American Gastroenterological Association	1,273 of 7,791 (16%)
American Geriatrics Society	724 of 2,750 (26%)
American Orthopaedic Association	387 of 1,665 (23%)
American Psychiatric Association	6,837 of 25,719 (27%)
American Roentgen Ray Society	2,533 of 13,859 (18%)
American Society for Aesthetic Plastic Surgery	330 of 1,888 (17%)
American Society of Abdominal Surgeons	no data
American Society of Breast Surgeons	609 of 2,473 (25%)
American Society of Interventional Pain Physicians	652 of 2,587 (25%)
American Society of Retina Specialists	575 of 2,154 (26%)
American Vein and Lymphatic Society	238 of 957 (25%)
Association of University Radiologists	179 of 861 (20%)

Organization	AMA Membership of Organization's Total Eligible Membership
Heart Rhythm Society	656 of 3,040 (22%)
Infectious Disease Society of America	1062 of 3,515 (30%)
International Academy of Independent Medical Evaluators	61 of 139 (44%)
International Society for the Advancement of Spine Surgery	109 of 369 (29%)
Society of Hospital Medicine	2,389 of 12,827 (19%)
The Triological Society	123 of 534 (23%)
Undersea and Hyperbaric Medical Society	123 of 586 (21%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association 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.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

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

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1, November 2020

Subject:	Bylaw Accuracy: Name Change for Accreditation Body for Osteopathic Medical Schools
Presented by:	Madelyn E. Butler, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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Recently, the Council learned that existing bylaw language regarding the accrediting body for osteopathic medical schools is inaccurate. The Commission on Osteopathic College Accreditation is the U.S. Department of Education-recognized accreditor; the American Osteopathic Association is the sponsoring organization.

The Council has prepared this report with appropriate bylaw amendments to ensure that the AMA Constitution and Bylaws remains an accurate document. The Council also will amend the glossary to the Bylaws which references American Osteopathic Association accreditation of medical schools.

RECOMMENDATIONS

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

1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active Constituent, Active Direct, Affiliate, Honorary, and International.

1.1.1 Active Membership.

1.1.1.1 Active Constituent. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation

~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.2 Active Direct. Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have been granted representation in the House of Delegates. Active direct members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation ~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2, November 2020

Subject:	Discordance between Policy and Bylaws--CEJA Membership on AMA Committee on Conduct at AMA Meetings and Events
Presented by:	Madelyn E. Butler, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Annual Meeting, our House of Delegates adopted Policy H-140.837, "Policy on Conduct at AMA Meetings and Events." This policy establishes a Committee on Conduct at AMA Meetings and Events (CCAM), "to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA)."

Current AMA Bylaw 6.5.5.1, however, states in part that "Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section."

The bylaw prohibition against a member of CEJA serving in any other AMA leadership or governance capacity was adopted by the House at the 1976 Annual Meeting, when CEJA was known as the Judicial Council. It and a similar provision that pertains to members of the Board of Trustees ensure a separation and independence of function for AMA's judicial, executive and legislative activities. The Council on Constitution and Bylaws understand that the CEJA member is an integral member of the CCAM. Also, one of the CCAM's options is referral to CEJA for further review and action.

The Council has developed an amendment to the AMA Bylaws for House consideration to allow service on the CCAM by a CEJA member. The Council will define the purpose of the CCAM in the glossary to the Bylaws.

RECOMMENDATIONS

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

6.5 Council on Ethical and Judicial Affairs.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

(Modify Bylaws)

RELEVANT AMA POLICY

H-140.837, Policy on Conduct at AMA Meetings and Events
It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.
Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an AMA Entity), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.
Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual s participation in such meetings or proceedings or, in the case of AMA staff, such individual s employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual s work performance, by instances of such conduct.
Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.
Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of

harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a Conduct Liaison for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, Policy on Conduct at AMA Meetings and Events during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, Policy on Conduct at AMA Meetings and Events, pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA s Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator s employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1, November 2020

Subject: Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics concerns in this area and offers guidance for physicians when they encounter patients who refuse or demand care based on what the patient perceives to be the physician's personal, rather than professional, characteristics. The Council recognizes that surrogates and family members may also engage in conduct that is disrespectful, derogatory or prejudiced but focuses here on such conduct directed toward physicians in light of physicians' unique fiduciary obligations to patients. Based on its deliberations and review of relevant literature, CEJA recommends that D-65.991 be addressed by amending Opinion 1.2.2, "Disruptive Behavior by Patients."

REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE

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

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

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physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced bias based on their ethnicity or religion somewhat more often than their female colleagues (24% versus 20% and 15% versus 8%, respectively) [8].

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

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

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

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

For physicians and health care institutions faced with patients' strongly held views about who should provide care, then, a central task is distinguishing when a patient's stated preference rests on ethically acceptable reasons and when it reflects unacceptable bias or prejudice [2, 9]. One challenge in making such an assessment, of course, is that in some situations time constraints or other factors may preclude being able to explore the factors that influence a patient's behavior.

PROTECTING INTERESTS, MINIMIZING HARMS

Patient refusals of care or demands for an alternative clinician challenge physicians, and the institutions in which they work, to protect both the interests of patients and those of physicians. In such situations, physicians' professional obligations to promote patient well-being, respect patients as moral agents and autonomous decision makers, and fulfill the duty to treat without discrimination come into tension in potentially novel ways. Nor do these responsibilities align with physicians' own interests in upholding professional autonomy and themselves being free from

discrimination. There are potential harms to both parties whether the physician/institution accommodates bigoted requests and removes the physician or requires patient and physician to engage one another in a troubled relationship.

Physicians' fiduciary obligations are fundamental. Physicians are expected to promote patients' interests 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]. 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].

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].

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 medical 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].

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?

Thwarting the requests of seemingly bigoted patients for alternative clinicians 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. 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 clinicians for which accommodation may be appropriate.

For physicians and other clinicians, 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 institutional culture that routinely subjects minority physicians to "barrages of microaggressions and biases" or expects them to serve as "race/ethnicity ambassadors" [1].

Institutions that fail to support staff in the face of prejudice convey that complying with patient demands "is more important than respecting the dignity of both their staff members and the majority of patients, who do not hold such repugnant views (or at least do not openly act on them)" [9]. Institutions, some argue, "have a duty to present a moral face to their community by refusing to honor bigoted or prejudicial requests or demands as a matter of course, up to and including declining to care for such patients (except in emergency situations)" [9, cp. 20].

Regardless of how their institutions respond, for many minority health care professionals, interactions with prejudiced patients are painful and degrading and contribute to moral distress and burnout [4]. *Requiring* physicians to provide care when a patient has openly expressed bias is not ethically tenable. As one physician described his own experience of ultimately declining to work with a particular patient, "After years of feeling that my race was a nonissue, I was subjected to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not having thicker skin began to creep in, I decided that, on this occasion, my feelings would count" [21]. Absent unique situations, institutions should allow physicians to control the decision about whether they will continue to provide care [19]. Some have argued that institutions have a responsibility to monitor such encounters and their effects on an ongoing basis "with the goal of supporting staff and improving the handling of these situations" [4].

Whether patient prejudice against physicians adversely affects quality of care has not been well studied. One experimental study among family practice physicians in the Netherlands concluded that "disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors" [22]. A companion study attributed this to the fact that the "mental resources" devoted to dealing with patient behavior interfered with "adequate processing of clinical findings" [23]. Evidence does indicate that physician "burnout" can adversely affect patient outcomes [e.g., 24–26]. To the extent that being the target of patient prejudice contributes to the emotional exhaustion, sense of depersonalization, and sense of low personal accomplishment characteristic of burnout, it is reasonable to expect biased behavior to be associated with lower quality of care, particularly if targeted physicians feel they do not have the support of their colleagues or institutions when bias occurs [1, 21, 27, 28].

LAW AND POLICY

Legally, at the federal level how a health care institution responds to prejudiced behavior by patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act* (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA). For example, when weighing patient requests for accommodation based on the physician's race, hospitals are in the position of having to meet EMTALA requirements while respecting physicians' employment rights [4]. Hospitals can "inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful speech," but their ability "to remove physicians in response to race-based requests is circumscribed" [4]. Although physicians have not sued under CRA [4], in a case that ultimately settled, an African-American nurse in Michigan sued her employer when she was barred from caring for a white baby at the request of the child's father, a white supremacist [29].

At present, relatively few institutions have formal policy or procedures for dealing with incidents of patient prejudice, although an increasing number broadly enjoin patients to behave in a respectful manner under policies delineating patient rights and responsibilities and indicate that misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto's University Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of patients and health care personnel.

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

RECOMMENDATION

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

> The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.
>
> Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either ~~physicians~~ patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.
>
> Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:
>
> (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.
>
> (b) Always treat patients with compassion and respect.
>
> (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) Prioritize the goals of care when deciding whether to decline or accommodate a patient's ~~prejudiced~~ request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.

(e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.

(f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

(g) Terminate the patient-physician relationship ~~who uses derogatory language or acts in a prejudiced manner~~ only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance.

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

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

(i) Educate staff, patients, and the community about the institution's expectations for behavior.

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

(k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.

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

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2, November 2020

Subject: Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Growing public skepticism about immunization, falling rates of immunization and the associated resurgence of infectious childhood diseases, and the emergence of new zoonotic diseases that have spread rapidly through human populations underscore the importance of physicians' responsibilities to protect the welfare not only of individual patients, but also of communities. Given heightened awareness of physicians' public health role, the Council on Ethical and Judicial Affairs reviewed ethics guidance set out in Opinion 8.7, "Routine Universal Immunization of Physicians." The following report summarizes the council's deliberations and clarifies its guidance on physicians' responsibility to accept immunization when a safe, effective vaccine is available, especially for a disease that has potential to become epidemic or pandemic.

VACCINATION OF HEALTH CARE WORKERS

Vaccination of health care workers, including physicians, is a logical measure to decrease transmission of vaccine-preventable diseases during patient encounters. Yet despite extensive education on the benefit of vaccination, recommendations from the Society for Healthcare Epidemiology of America [1,2], and strong efforts by health care institutions to promote this preventive measure, rates of vaccination among health care workers can be surprisingly low, especially for seasonal influenza [3].

Requiring vaccination of health care workers does increase vaccination rates for seasonal influenza [3,4]. One multispecialty medical center achieved an influenza vaccination rate of approximately 98 percent among health care workers by requiring vaccination, with exemptions for medical and religious reasons [3]. A study comparing medical centers with and without an influenza vaccine mandate showed a 30 percent difference in vaccination rate between the two groups [4]. The study also found a decrease in days absent for symptomatic influenza-like illness (ILI) for the mandatory vaccination group.

However, the available evidence, most of which comes from observational studies, is mixed regarding the extent to which mandated vaccination of physicians and other health care workers benefits patients [5,6,7]. One meta-analysis of studies from facilities that offered influenza vaccination reported a reduction in all-cause mortality and ILI, but did not show changes in hospitalizations and confirmed cases of influenza [8]. A Cochrane meta-analysis that focused on assessing whether influenza vaccination for health care workers in long-term care institutions similarly did not find significant effect of vaccination in decreasing hospitalizations or confirmed

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cases of influenza among residents [9]. There is a paucity of randomized controlled trials that directly assess the effect of vaccination mandates or campaigns on patient health. One European trial that assessed the impact of a multi-faceted influenza vaccination program for health care workers did find a 5.8 percent reduction in nosocomial cases of influenza and/or pneumonia among hospitalized patients [10].

Critics have observed significant methodological flaws in these studies, including multiple sources of bias and violation of the principle of dilution, casting doubt on the studies' validity [6,7]. This has led proposals for alternatives to mandatory vaccination of health care workers, such as strategies to reduce "presenteeism" (working while ill), which can drastically affect the transmission of influenza [6].

LAW & POLICY

Law and policy throughout the United States require immunizations or other documentation of immunity as a condition of public school attendance and, in some cases, as a condition of employment [11]. Historically, in decisions in *Jacobson v. Massachusetts* [12] and *Zucht v. King* [13], the U.S. Supreme Court has held that states can mandate immunizations to protect public health, but, if they do, they must also allow medical exemptions. Courts have further held that the exemption process must not violate the individual's constitutional rights. Thus, most states must also provide for non-medical exemptions to accommodate religious beliefs of some individuals who oppose immunization [14]. Some states also provide non-medical exemptions for individuals who oppose immunization for personal or philosophical reasons [14].

State laws mandating vaccination of health care workers vary across the country. For example, as of 2017, eight states require that a hospital "ensure" its health care personnel are vaccinated for seasonal influenza; 11 others require only that hospitals "offer" a flu vaccine to their employees [15]. States also vary with respect to whether they recognize exemptions and which exemptions—medical, religious, philosophical—they allow [15].

Employers of health care workers may implement their own mandatory vaccination programs under contractual employment law, as hundreds of facilities around the country have done [16]. Title VII of the Civil Rights Act prohibit religious discrimination and thus requires that employers consider religious exemptions to vaccination and implement such exemptions so as to ensure that any vaccine mandate is nondiscriminatory. Employers must also generally ensure that mandatory vaccination programs allow appropriate medical exemptions for individuals with a disability that would be adversely affected by vaccination [17]. In requiring employers to keep the workplace free of hazards, the Occupational Health and Safety Act may impose a duty on employers to encourage or mandate vaccination to prevent employees from contracting or spreading serious diseases in the workplace [17].

Policies of the AMA House of Delegates generally support physician immunization. H-225.959, Staff Medical Testing, maintains that, when local statute and regulation do not provide for immunization of health care personnel, hospital medical staffs should determine which tests or immunizations are to be required for members of the medical staff and "delineate under what circumstances such tests or immunizations should be administered."

Policy also opposes non-medical exemptions, including non-medical exemptions from mandated pediatric immunizations. H-440.970, Non-Medical Exemptions from Immunization, supports eliminating non-medical exemptions from immunization and encourage physicians to grant exemption requests "only when medical contraindications are present." AMA policy further

supports restricting the activity of medical staff who are not immunized. In the specific context of Hepatitis B, for example, H-440.949, Immunity to Hepatitis B Virus, requires that medical staff who do not have immunity from a natural infection or who have not been immunized, "either be immunized or refrain from performing invasive procedures."

PHYSICIANS' ETHICAL RESPONSIBILITIES

Physicians have well-recognized professional responsibilities to protect the health of their individual patients (Principle VIII, Opinion 8.11, "Health Promotion and Disease Prevention"). They also have responsibilities to protect the health of the community at large (Principle VII, Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness"). And they have an obligation to protect their own health and that of their colleagues and other members of the health care workforce (Principle X, Opinion 9.3.1, "Physician Health and Wellness"; Opinion 8.3; Opinion 8.4, "Ethical Use of Quarantine and Isolation").

Responsibility to Protect

In the context of a health care crisis—e.g., epidemic, disaster, or terrorism—physicians' ethical obligation is to subordinate their personal interests to those of their patients. Their first duty, set out in Opinion 8.3, is to "provide urgent medical care . . . even in the face of greater than usual risk to physicians' own safety, health or life." Opinion 8.3 recognizes that the physician workforce itself is not an unlimited resource, however. Thus, physicians are expected to assess the risks of providing care to individual patients in the moment against the ability to provide care in the future. Opinion 8.4 similarly requires physicians to "protect their own health to ensure that they remain able to provide care."

Taken together, these considerations argue strongly for a responsibility on the part of physicians to accept immunization against vaccine-preventable diseases—unless there are compelling reasons for the individual not to receive a specific vaccine. Medical exemptions from vaccination are intended to prevent harm to individuals who are at increased risk of adverse events from the vaccine because of underlying conditions. Vaccines are medically contraindicated for individuals who have histories of severe allergic reactions from prior doses of vaccine. Many underlying conditions also place individuals at increased risk of complications from certain vaccines as well as from the diseases they prevent. For example, individuals who are severely immunocompromised should not be inoculated with vaccines containing live attenuated viruses, such as the varicella zoster (chicken pox or shingles) or measles, mumps, and rubella (MMR) vaccines [18]. Individuals for whom vaccines are medically contraindicated are protected from exposure to vaccine-preventable diseases through herd immunity by ensuring high rates of coverage among the rest of the population.

The relative strength of the responsibility to accept vaccination is conditioned on several factors, including how readily a given disease is transmitted; what medical risk the disease represents for patients, colleagues, and society; the individual's risk of occupational exposure; the safety and efficacy of available vaccine(s); the effectiveness and appropriateness of immunization relative to other strategies for preventing disease transmission; the medical value or possible contraindication of immunization for the individual [19], and the prevalence of the disease. Unless medically contraindicated, the more readily transmissible the disease and the greater the risk to patients and others with whom the physician comes into contact relative to risks of immunization to the physician, the stronger the physician's duty to accept immunization. Physicians should not be required to accept immunization with a novel agent until and unless there is a body of scientifically well-regarded evidence of safety and efficacy.

It is not ethically problematic to exempt from vaccination an individual with medical contraindications. Ethical concerns arise when individuals are allowed to decline vaccinations for non-medical reasons. The rationale for non-medical exemptions must strike a prudent balance among multiple interests and values, including the welfare of individuals, groups and communities; respect for civil liberties and autonomy; and fairness.

In general, society respects individuals' freedom to make health care decisions for themselves in keeping with their religious commitments, and within limits, decisions based on personal beliefs that are not encoded in specific religious doctrine per se. Ideally, those beliefs will comprise a "substantive, coherent, and relatively stable set of values and principles" to which the individual is genuinely committed and that are reflected broadly in the individual's decisions and actions [20].

Individuals who have direct patient contact should rightly expect their autonomy to be respected when their personal health choices do not put others at risk of harm [21]. In certain circumstances physicians should refrain from being immunized in order to protect the well-being of their patients; for example, if receiving a live virus vaccine would put immune-compromised or never-immunized patients at risk during the time the physician may transmit the attenuated virus.

Aside from these limited circumstances, however, physicians and other health care workers who decline to be vaccinated do put others at risk for vaccine-preventable disease. In deciding whether to decline vaccination, therefore, physicians have a responsibility to strike an ethically acceptable balance between their personal commitments as moral individuals and their obligations as medical professionals. Those who cannot or choose not to be immunized when a safe, effective, and well-tested vaccine is available must take other steps to protect themselves and those to whom they may transmit a vaccine-preventable disease, which may include refraining from patient contact.

Arguably, physicians' responsibility to protect patients' well-being extends to ensuring that all staff in their own practices are vaccinated, absent medical contraindication; when they or their staff are not immunized, physicians must protect themselves and patients in other ways. At a minimum, physician-leaders in practices and health organizations should require that staff who come into contact with high-risk patients take appropriate protective measures.

Responsibility to Promote Shared Decision Making

As trusted sources of information and guidance, physicians can play a significant role in shaping their patients' perspectives about vaccines and the decisions patients make about immunizing themselves and their families [22-27]. In keeping with practices recognized for increasing uptake of childhood immunizations, physicians have a responsibility to educate patients about the risks of forgoing or delaying a recommended immunization [28]. Exploring with vaccine hesitant patients their reasons for declining recommended immunizations is crucial. Vaccine hesitant patients commonly misunderstand physicians' motivation for urging immunization, but when reminded that their physician is motivated first and foremost by their welfare instead of public health concerns are more receptive to considering immunization [28]. Candor, willingness to listen, encouraging questions, and respectfully acknowledging patients'—or parents—concerns are essential elements of conversations with vaccine-hesitant individuals [28].

Physicians also serve as role models for their patients, consciously or otherwise. Physicians who adhere to immunization requirements and recommendations for themselves and their children can be powerful motivators for patients, colleagues, and others in the community to pursue immunization [2]. Physicians can take advantage of their power to motivate by communicating that

they themselves have been immunized. By the same token, physicians who fail to follow their own advice risk compromising patients' trust and undermining their credibility as advisors.

RESPONSIBILITIES OF HEALTH CARE INSTITUTIONS

Medicine is fundamentally a moral activity, and as sites in which that activity is carried out, health care institutions share the profession's "commitment to fidelity and service" [29]. They have obligations to the communities of patients the institution serves, to the physicians and other health care professionals who provide hands-on care, and to the other personnel who support those activities. Opinion 11.2.6, "Mergers of Secular and Religiously Affiliated Institutions," holds that "[p]rotecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it" is an essential responsibility.

Health care institutions discharge this responsibility by proactively developing policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedure should include robust infection control practices, providing appropriate protective equipment, and a program for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of their staff. Health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from patient care activities or other direct patient contact.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and deletion as follows and that the remainder of this report be filed:

> As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.
>
> In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians ~~should:~~
>
> ~~Accept~~ have a responsibility to accept immunization absent a recognized medical~~, religious, or philosophic reason to not be immunized~~ contraindication or when a specific vaccine would pose a significant risk to the physician's patients.
>
> ~~(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain~~

~~from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.~~

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(November 2020)

Introduced by: Resident and Fellow Section

Subject: AMA Resident/Fellow Councilor Term Limits

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Based on a review of the foundational reports leading to the development of resident/fellow Council and BOT positions, the purpose of these roles is to maintain a resident voice in these bodies and to allow for residents and fellows to both gain experience in the election process and contribute meaningfully to practices of the Councils and BOT; and

Whereas, BOT Report A at the 1976 AMA Annual Convention, which codified resident and non-voting medical student representation on the Councils with three-year term lengths and a maximum three-term limit for the Council on Medical Education, Council on Medical Service, Council on Scientific Affairs, and the Council on Long Range Planning and Development (CLRPD); and

Whereas, Starting at the 1991 Annual Meeting, AMA House of Delegates Resolution 202 "Leadership Opportunities in the American Medical Association" called for a review of the AMA Board and Councils to increase the rate of involvement of, "various demographic segments of the AMA physician population in AMA leadership" and the subsequent study period yielded a survey of AMA members showing, "57% favored reducing the maximum tenure of Council members"; and

Whereas, During the 1996 Interim Meeting of the AMA, CLRPD presented Report 2 "Terms of Service of AMA Councils" which discussed some of the history of Council term lengths and presented arguments for and against one-, three-, five-, and seven-year terms for AMA Councils, considering "(a) the frequency of campaigns for Council positions, (b) the responsiveness of Council members to the AMA membership, the House and the Board, (c) opportunities to replace Council members whose performance is problematic, and (d) compatibility with the maximum total number of years that individuals can serve on each Council"; and

Whereas, CLRPD I-96 Report 2 noted that shorter terms would lead to increased member responsiveness and ease in removal of ineffective Council members, but increase time and cost devoted to campaigns, while shorter terms would be better suited for task-oriented Councils such as the Council on Legislation; and

Whereas, The RFS has concerns that three-year resident/fellow Council positions would disproportionately inhibit members of specialties with shorter residency training periods from being represented, including Internal Medicine, Emergency Medicine, Pediatrics and Family Medicine; and

Whereas, Due to current term lengths residents/fellows in longer training programs are unintentionally favored for Council positions; and

Whereas, From 2005-2019 only five residents in three-year residencies without subsequent fellowship positions served as residents on AMA Councils over this 15-year period; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 48 seats (40.0%) were held by residents in three-year residencies, though only 13 seats (10.8%) were held by residents in three-year residencies without subsequent fellowship positions despite 57% of residents matching to a specialty with only 3 years of training; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 65.8% were held by residents either in training programs of 5 or more years or went on to fellowship training totaling 5 or more years during their term; and

Whereas, BOT Report W from 1983 titled "Resident Member of the AMA Board of Trustees" was adopted allowing for the creation of a resident Trustee with a term length of two years and a maximum three-term limit; and

Whereas, The Resident Member of the Board of Trustees has been an effective member of the Board of Trustees despite a term of only two years; and

Whereas, Residents with shorter training periods are disproportionately underrepresented in elected and appointment Council positions thus creating a disparity in representation between primary care residents and specialty-trained ones; and

Whereas, Two-year terms would allow for more opportunities for residents at all training programs, especially those in 3 or 4 year residencies to be represented on AMA councils; therefore be it

RESOLVED, That our American Medical Association amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.

6.5.7 Term.

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term. (Modify Bylaws)

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.6 Council on Long Range Planning and Development.

6.6.3 Term.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.5 Vacancies.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term. (Modify Bylaws)

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.3 Vacancies.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2~~3~~-year term. (Modify Bylaws)

Fiscal Note: Minimal - less than $1,000

Received: 08/25/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(November 2020)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The average age at completion of medical training in the United States is approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and

Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50% drop from the early 20s to late 30s[5]; and

Whereas, Female physicians have a chance of infertility that is twice that of the general population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and

Whereas, The demands of residency increase the risk of pregnancy complications, with a higher rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth restriction among female residents[6–8]; and

Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during training[9] and have concerns about workplace support,[10] which may deter medical students from choosing a career in a surgical or other field with longer and demanding training; and

Whereas, Approximately one third of program directors have reported discouraging pregnancy among residents in surgical training programs[10]; and

Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in addition to requiring timely injection of ovarian stimulation medications and numerous outpatient visits for cycle monitoring and egg retrieval[13]; and

Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for several years[14]; therefore be it

RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy)

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

Received: 08/25/20

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RELEVANT AMA POLICY:

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 003
(November 2020)

Introduced by: Resident and Fellow Section

Subject: Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the patient's right to accept, modify, and refuse treatment[1,2]; and

Whereas, A patient desiring treatment must provide informed consent which can only be given after being informed of their diagnosis, if known, the nature and purpose of any recommended interventions, and the anticipated risks, benefits, and consequences of all options[3–5]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed consent as "a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care"[6]; and

Whereas, A patient's provider is legally and ethically obligated to inform patients as part of the consent process any party who can be reasonably anticipated to be part in their care team including but not limited to residents, nurses, students, and allied health professionals[3,7]; and

Whereas, Teaching hospitals historically used the generalized consent form as permission to perform exams of the genital areas, including for educational purposes, without deliberately informing patients of opportunities to limit how any care teams or their members could be involved in their care experience[4,8–14]; and

Whereas, In the 1980s, women vocalized demands to be asked for additional explicit consent prior to undergoing educational pelvic exams in the operating room and indicated that doing so without this consent constituted physical asssult[15]; and

Whereas, Surveys conducted in 2003 in Philadelphia and 2005 in Oklahoma found medical students were still conducting educational pelvic and rectal exams on anesthetized or unconscious patients without having obtained prior consent to do so[12,16,17]; and

Whereas, Educational pelvic exams were historically performed on patients under anesthesia in operating rooms without explicit patient consent, including by medical students not directly involved or not reasonably anticipating to be involved with the patient's ongoing care and when the patient's surgical indications did not warrant a pelvic exam[18]; and

Whereas, Varying attitudes on educating medical students on invasive exams compounded with pressures on students to achieve high academic and clinical marks may contribute to erosion of consideration for scenarios when additional patient consent is indicated[16,19–24]; and

Whereas, The Association of American Medical Colleges (AAMC) and ACOG both emphasize that pelvic exams performed under anesthesia for educational purposes should only be done with a patient's informed consent prior to conducting the exam[4,24]; and

Whereas, Various states have passed legislation outlawing educational pelvic exams and/or pelvic exams in general, potentially even when indicated as part of a procedure, on a woman who is anesthetized or unconscious without prior consent to specifically do so[14,25–32]; and

Whereas, The Joint Commission maintains that patients may decline participating in elements of clinical training programs, such as working with medical students[12,33]; and

Whereas, The *AMA Code of Medical Ethics* states that patient "participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance."[34]; and

Whereas, While patients are often open to learner involvement in their care, they may deem scrutiny of more private body parts, particularly when solely for educational purposes, to warrant specific consent beyond the level provided for general care and treatment[15,35–37]; and

Whereas, Use of professional standardized patients who teach female pelvic, male genitourinary, and rectal exams have already demonstrated significant value in medical education and further highlight the unnecessary nature of educational genital exams performed without explicit patient consent[38–40]; therefore be it

RESOLVED, That our American Medical Association oppose performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so (New HOD Policy); and be it further

RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia (New HOD Policy); and be it further

RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm policy H-320.951, "AMA Opposition to "Procedure-Specific" Informed Consent." (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 08/25/20

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RELEVANT AMA POLICY:

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

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

2.1.6 Substitution of Surgeon
Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the surgeon has an ethical responsibility to:
(a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.
(b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines.

2.3.6 Surgical Co-Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.

(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

7.1.2 Informed Consent in Research
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:
(a) Ascertaining that the individual has decision-making capacity.
(b) Reviewing the process and any materials to ensure that it is understandable to the study population.
(c) Disclosing:
(i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
(ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
(iv) the likelihood of therapeutic or other direct benefit for the participant;
(v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
(vi) the nature of the research plan and implications for the participant;
(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
(d) Answering questions the prospective participant has.
(e) Refraining from persuading the individual to enroll.
(f) Avoiding encouraging unrealistic expectations.
(g) Documenting the individual's voluntary consent to participate.
Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:
(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.
(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
(j) There is potential for the individual to benefit from the study.
In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

9.2.1 Medical Student Involvement in Patient Care
Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment. All physicians share an obligation to ensure that

patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should: (a) Convey to the patient the benefits of having medical students participate in their care. (b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients. (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated. (d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity. (e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2 Resident & Fellow Physicians' Involvement in Patient Care
Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals. Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should: (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow. (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients. (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients. Physicians involved in training residents and fellows should: (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity. (e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility. (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students
Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as "patients" are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students' privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:
(a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
(b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
(c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.
(d) Allow students the choice of whether to participate prior to entering the classroom.
(e) Never require that students provide a reason for their unwillingness to participate.
(f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students' overall performance based on their willingness to volunteer as "patients."
Citation: Issued 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.
Citation: Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 04, A-20

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.
(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(November 2020)

Introduced by: Virginia, American Association of Clinical Urologists, Oklahoma, West Virginia, Maryland, Mississippi, North Carolina, Kentucky, American Urological Association

Subject: Nonconsensual Audio/Video Recording at Medical Encounters

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Fifteen percent of physician-patient visits may be unknowingly recorded with the ubiquitous use of smartphones and other technologies; and

Whereas, Thirty-nine states and the District of Columbia conform to a single-party consent rule for recording a conversation between two parties. Eleven states (California, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania, and Washington) require consent of both parties[1]; and

Whereas, Audio/video recording of a medical encounter may be of benefit for a patient to recall the pertinent issues and instructions given. Conversely, a covert recording made without the physician or patient's knowledge may erode trust and harm the physician-patient relationship; therefore be it

RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 06/08/20

References:
1 Elwyn G, Barr PJ, Castaldo M. Can Patients Make Recordings of Medical Encounters? What Does the Law Say? JAMA. 2017;318(6):513–514. doi:10.1001/jama.2017.7511

RELEVANT AMA POLICY

E-3.1.3. Audio or Visual Recording Patients for Education in Health Care
Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.
To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:
(a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
(b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):

(i) about the purpose of recording, the intended audience(s), and the expected distribution;
(ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
(iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patients care;
(iv) that the patient may withdraw consent at any time and if so, what will be done with the recording;
(v) that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
(d) Ensure that the patient has had opportunity to discuss concerns before and after recording.
(e) Obtain consent from a patient (or the authorized decision maker):
(i) prior to recording whenever possible; or
(ii) before use for educational purposes when consent could not be obtained prior to recording.
(f) Respect the decision of a patient to withdraw consent.
(g) Seek assent from the patient for participation in addition to consent by the patients parent or guardian when participation by a minor patient is unavoidable.
(h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the films educational content and value.
(i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
(j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records.
AMA Principles of Medical Ethics: I,IV,V,VIII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

E-3.1.4 Audio or Visual Recording of Patients for Public Education
Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld. Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).
Physicians involved in recording patients for public broadcast should:
(a) Participate in institutional review of requests to record patient interactions.
(b) Require that persons present for recording purposes who are not members of the health care team:
(i) minimize third-party exposure to the patients care; and
(ii) adhere to medical standards of privacy and confidentiality.
(c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
(d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
(e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(f) Inform a patient (or authorized decision maker) who is to be recorded:
(i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
(ii) about the intended audience(s);
(iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
(iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
(v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
(vi) whether the physician was compensated for his participation and the terms of that compensation.
(g) Ensure that the patient has had the opportunity to address concerns before and after recording.
(h) Ensure that the patients consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
(i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patients care) perceives that recording may jeopardize patient care.
(j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
(k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record.
AMA Principles of Medical Ethics: I,IV,VII,VIII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(November 2020)

Introduced by: Medical Student Section

Subject: Racism as a Public Health Threat

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Underrepresented or marginalized racial and ethnic populations in the United States have shorter lifespans, greater physical and mental illness burden, earlier onset and more aggressive progression of disease, higher maternal and infant mortality, and less access to healthcare services[1-11]; and

Whereas, Systemic racism is defined as a structural and legalized system that results in differential access to goods and services, including health services[5,9,12,13]; and

Whereas, Cultural racism refers to negative and harmful racial stereotypes portrayed in culturally shared media and experiences[5,9,12,13]; and

Whereas, Interpersonal racism is implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices[5,9,12,13]; and

Whereas, Systemic racism results in segregation of marginalized, racialized groups to less financially supported neighborhoods, schools, and jobs, lower salary for the same work, lower rates of promotion despite similar performance and higher rates of incarceration and police violence, all of which contribute to health inequities and have been independently associated with worse health outcomes[5,9,13-23]; and

Whereas, Interpersonal racism has been independently associated with chronic pain, poorer sleep, lower likelihood of accessing preventive screenings or prenatal care, psychosocial distress, greater likelihood of alcohol use and smoking, and lower overall health[5,24-26,28-31]; and

Whereas, In healthcare, systemic and cultural racism result in less access to care for minority groups and in different groups routinely receiving different treatment for the same complaints[9-10,13,32-34]; and

Whereas, When interpersonal racism is committed by healthcare workers, which occurs frequently, it undermines the physician-patient relationship, harms patients' trust in the healthcare field as a whole, and makes patients less likely to seek needed care[9,12,26,27,33-39]; and

Whereas, Experiencing perceived racial discrimination induces a chronic stress response causing heritable, intergenerational epigenetic changes, compounding disparities in health outcomes and chronic disease incidence that exist even when controlling for other socioecological factors[3,40-45]; and

Whereas, Rates of reported hate-based crimes and public expressions of discrimination against racial and ethnic minorities have increased in recent years[30,46-53]; and

Whereas, The role of racism in creating and perpetuating health disparities is frequently overlooked in research and healthcare literature and policy[5,13]; and

Whereas, Though developing technologies have potential to provide great improvement to health and well-being, they have also been shown to have an alarming capacity for absorbing, perpetuating, and compounding racism in healthcare on a massive, industry-wide scale, making it clear that a proactive approach to prevent or identify and eliminate racism in technologies as they are created is crucial[54-57]; and

Whereas, Though AMA policies emphasize the need to eliminate racial and ethnic disparities in health (H-350.974, D-350.984, D-350.995, H-350.953, D-350.991, H-440.869, H-65.963) and calls upon physicians to actively work to prevent violence of all kinds (H-515.964, H-515.971, H-515.979, H-145.970), AMA policy currently does not recognize the role of racism in perpetuating health disparities and inciting violence against minority groups; and

Whereas, At the June 2020 Special Meeting our AMA Board of Trustees made a statement recognizing racism as an urgent threat to public health and resolving to “actively work to dismantle racist and discriminatory policies and practices across all of health care"; therefore be it

RESOLVED, That our American Medical Association acknowledge that historic and present racist medical practices have caused and continue to cause harm to marginalized communities (New HOD Policy); and be it further

RESOLVED, That our AMA recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care (New HOD Policy); and be it further

RESOLVED, That our AMA identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, and populations (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:

1. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and
2. How to prevent and ameliorate the health effects of racism (New HOD Policy); and be it further

RESOLVED, That our AMA: (a) support the development of policy to combat racism and its effects; (b) encourage governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them (New HOD Policy); and be it further

RESOLVED, That our AMA work to prevent and combat the influences of racism and bias in innovative health technologies. (Directive to Take Action)

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

Received: 10/13/20

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RELEVANT AMA POLICY

Violence Activities H-515.964

Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes;
(2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and
(3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. (BOT Rep. 9, A-03, Reaffirmed: CSAPH Rep. 1, A-13, Reaffirmation: A-18)

Public Health Policy Approach for Preventing Violence in America H-515.971

The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts. (BOT Rep. 34, A-95, Reaffirmed: BOT Rep. 16, A-96, Reaffirmed: CSAPH Rep. 3, A-06, Reaffirmation: A-13, Reaffirmation: A-18)

Violence as a Public Health Issue H-515.979

The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub Res. 408, I-92, Amended: CSA Rep. 8, A-03, Reaffirmation: A-13, Reaffirmed: CSAPH Rep. 1, A-13, Reaffirmation: A-18)

Nondiscrimination in Responding to Terrorism H-65.978
Our AMA: (1) affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism. (Res. 1, I-01, Modified: CSAPH Rep. 1, A-11)

E-8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

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

Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients. (Issued: 2016)

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign. (BOT Action in response to referred for decision, Res. 602, I-15)

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. (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)

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

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (Res. 405, A-18)

Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; (3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and (4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. (Res. 409, A-09, Appended: Res. 416, A-11)

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. (Res. 406, A-16, Modified: BOT Rep. 28, A-18)

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. (CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmed: CEJA Rep. 01, A-20)

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. (Res. 914, I-07, Modified: BOT Rep. 22, A-17)

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Res. 001, A-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. (CCB/CLRPD Rep. 3, A-14, Reaffirmed in lieu of: Res. 001, I-16, Reaffirmation: A-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(November 2020)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, AMA Policy H-65.961, "Principles for Advancing Gender Equity in Medicine," notes that the AMA opposes any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender); and

Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and their experiences with workplace discrimination indicated that 77.9% of the respondents experienced some form of discrimination;[1] and

Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender discrimination and 35.8% reported experiencing maternal discrimination, which is defined as self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;[1] and

Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the Civil Rights Act of 1964, protects individuals from discrimination based on protected class such as, sex, gender and pregnancy;[2] and

Whereas, The Fair Labor Standards Act includes some breastfeeding protections;[3] and

Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in physicians experiencing maternal discrimination compared to 33.9% burnout in those not experiencing maternal discrimination);[1] and

Whereas, Male physicians are increasingly expressing interest in flexible family leave and work options, yet female physicians continue to bear primary responsibility for caregiving and may face more challenges in aligning their career goals with family needs; and

Whereas, Conflicts between work and life responsibilities can have adverse consequences for women physicians; and

Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women who are employed full time spend an additional 8.5 hours per week on childcare and other domestic activities;[4] and

Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion of paid parental leave; calls for improved social and economic support for paid family leave to care for newborns, infants and young children; and advocates for federal tax incentives to support early child care and unpaid child care by extended family members; and

Whereas, Assistance with lactation support and flexible scheduling, coupled with comprehensive parental leave policies, can foster work-life integration and help mitigate maternal discrimination in the workplace; therefore be it

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which may encompass pregnancy, parental leave, breastfeeding, and breast pumping. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/20

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1. Adesoye T, Mangurian C, Choo EK, et al. Perceived Discrimination Experienced by Physician Mothers and Desired Workplace Changes: A Cross-sectional Survey. *JAMA Intern Med.* 2017;177(7):1033-1036.
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4. Templeton K, Bernstein CA, Sukhera J, et al. Gender-Based Differences in Burnout: Issues Faced by Women Physicians. Available at https://nam.edu/gender-based-differences-in-burnout-issues-faced-by-women-physicians/. Accessed 3/10/2020.

RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents

to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

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

Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
Res. 215, I-16; Appended: BOT Rep. 11, A-19

E-9.5.5 Gender Discrimination in Medicine
Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.
Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication.
AMA Principles of Medical Ethics: II,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(November 2020)

Introduced by: Michael M. Miller, MD, Delegate

Subject: Access to Confidential Health Care Services for Physicians and Trainees

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Mental disorders and addictive disorders are serious medical conditions, and can be severe, leading to significant distress and dysfunction; and

Whereas, Despite years of education and advocacy, these conditions remain associated with stigma, and persons with these conditions can face discrimination, including in the workplace; and

Whereas, Physicians and medical students also experience mental disorders and addictive disorders, but they tend to avoid seeking professional help, often due to concerns about the impact of such care-seeking on their professional status and their ability to advance through training without discrimination; and

Whereas, The COVID-19 pandemic has intensified the stresses on practicing physicians, fellows, residents and medical students, with increased rates of anxiety disorders, mood disorders, posttraumatic stress disorder, and substance-related problems; and

Whereas, Physicians and trainees need access to confidential health care services and barriers to care-seeking should be removed for these groups; and

Whereas, Similar stresses and mental and addictive disorders have befallen all licensed independent practitioners (physicians, dentists, podiatrists, optometrists, psychologists), advanced practice practitioners (nurse practitioners, CRNAs, nurse midwives and physician assistants) and other professionals in clinical roles (nurses, mental health therapists, addiction counselors); and

Whereas, Most health professionals have health insurance benefits or coverage via self-insured employers, but in many cases, especially when the health system that employs them has an ownership stake in a health plan, the in-network providers are employed in the same system where the clinician or trainee works or is in training, leading to challenges to maintaining confidentiality and extra hesitancy on the part of those in need of mental health or addiction services to seek help; and

Whereas, Differences in costs of care for in-network vs out-of-network providers can be a deterrent to an individual deciding to seek behavioral health care services or continue in treatment; and

Whereas, Rates of suicide among physicians, especially women physicians, continue to climb, and professions such as medicine should do all they can to assist their peers to have access to high quality and confidential behavioral health care services; and

Whereas, Some health systems recognize these variables, and work closely with health plans to assure that physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors are able to go out-of-network to see a mental health or addiction professional who does not work in the same health system as the employee, and at in-network rates; and

Whereas, The primary care physician is the first point of contact for many persons with mental disorders and addictive disorders, and the relationship with one's primary care provider may have a level of intimacy that approximates that which a person has with a behavioral health care professional; therefore be it

RESOLVED, That our American Medical Association advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors, should encourage them to maintain self-care and to seek professional help from a mental health professional or addiction professional when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors should do all they can to reduce stigma, reduce or eliminate discrimination, and remove barriers to treatment entry for those who need professional behavioral health care services (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers in the health care sector including academic medical centers where residents and fellows are trained, as well as medical schools, who offer health benefits to their employees, fellows, residents and medical students, and where there is a defined set of in-network providers, should assure that physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors are able to go out-of-network to see a mental health or addiction professional who does not work in the same health system as the employee (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that fellows, residents and medical students be provided access to out-of-network providers when they are seeking to establish care with a primary care provider, so that they are able to use their health insurance benefits while not finding themselves under the care of a past, current or future faculty member, if the original provider network does not contain adequate options for primary care offered by clinicians not on the faculty of the medical school or academic medical center; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate that contracts should be established by medical schools, academic medical centers, and employers of practicing physicians such that the deductibles, copays, coinsurance, and out-of-pocket maximums for such practicing physicians, fellows, residents and medical students seeing out-of-network providers of mental health, addiction, and primary medical care should be the same as the deductibles, copays, coinsurance, and out-of-pocket maximums for seeing in-network providers. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/05/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(November 2020)

Introduced by: Mississippi, Alabama, Florida, South Carolina, West Virginia, Puerto Rico, Tennessee, New Jersey, Oklahoma, Virginia, Georgia, Louisiana, Kentucky, North Carolina, District of Columbia

Subject: Delegate Apportionment During COVID-19 Pandemic Crisis

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The COVID-19 pandemic has been difficult for our country including the practice of medicine; and

Whereas, Many medical practices and hospitals have had to reduce the number of patients that they see and reduce the number of procedures that they perform. This in turn has reduced many physicians' revenue and, as a consequence, many physicians have elected not to renew their memberships in many organizations including their medical societies and associations; and

Whereas, Because of the COVID-19 pandemic crisis, many medical societies, state medical associations, and specialty associations have not been able to meet in person. As a result, these organizations have not had the usual platform to promote the importance of organized medicine and have seen a drop in membership including AMA membership; and

Whereas, States that have had a significant number of state and national medical associations and/or academies have made accommodations for their membership as a result of the Covid 19 pandemic; therefore be it

RESOLVED, That our American Medical Association extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(November 2020)

Introduced by: Minority Affairs Section

Subject: Support of Learner and Trainee Participation in Peaceful Demonstrations and Other Forms of Public Advocacy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The recent killings of unarmed Black men and women resulted in increased civic, social, and political engagement among learners and trainees through participation in various forms of peaceful demonstrations to bring attention to the historical, structural, and systemic racism experienced by people and communities of color that have led to continued health inequities, including police brutality; and

Whereas, Learners and trainees have expressed fear or hesitation of engaging in public advocacy due to fear of consequence or perceived impact their participation will have on their academic careers; and

Whereas, Learners and trainees have reported restrictive institutional policies forbidding their involvement as well as experiences of institutional retaliation because of their participation; and

Whereas, In July 2020, The Association of American Medical Colleges (AAMC) issued *Guidance on Peaceful Protests by Medical Students and Residents,* highlighting the benefits of learner and trainee participation in their professional development as socially conscious physicians of tomorrow[1]; therefore be it

RESOLVED, That our American Medical Association issue guidance to protect and support learner and trainee participation in peaceful demonstrations and other forms of public advocacy. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/13/20

References:
1. AAMC Guidance on Peaceful Protests by Medical Students and Residents https://www.aamc.org/system/files/2020-07/AAMC_Guidance_for_Students_Schools_on%20Peaceful_Protests_07072020.pdf

RELEVANT AMA POLICY

Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End

Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.
Citation: (Res. 409, A-09; Appended: Res. 416, A-11)

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
Citation: BOT Action in response to referred for decision Res. 602, I-15

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 decisionmaking 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

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
Citation: (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

Fair Process for Employed Physicians H-435.942
1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.
Citation: Res. 007, I-16

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)

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.
Citation: Res. 405, A-18

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public

health communities, to define serious injuriesfor the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
Citation: CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Citation: Res. 914, I-07; Modified: BOT Rep. 22, A-17

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Citation: Res. 001, A-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: 010
(November 2020)

Introduced by: Minority Affairs Section

Subject: Racial Essentialism in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, At the turn of the twentieth century, sociologist and civil rights leader W.E.B. DuBois synthesized sociological and scientific evidence to conclude that race is not a scientific category, and rather that racial health disparities stemmed from social, not biological, inequalities[1]; and

Whereas, "Racial essentialism" is defined as the belief in a genetic or biological essence that defines all members of a racial category[2–4]; and

Whereas, The modern scientific consensus is that race is a social construct based on prevailing societal perceptions of physical characteristics, and that there are no underlying biological traits that unite people of the same racial category[3–15]; and

Whereas, Race as a variable has been inconsistently defined in research literature, clinical practice guidelines, and even U.S. Census categorizations[5,8,12–14,16–22]; and

Whereas, Race is often inappropriately conflated with ethnicity, which led to passage of AMA policy recognizing that race and ethnicity are conceptually distinct (H-460.924)[8,15,16,23]; and

Whereas, Decades of rigorous genetics research has confirmed that genetic and biological variation exists within and among populations across the planet, and groups of individuals can be differentiated by patterns of similarity and difference, but these patterns do not align with socially-defined racial groups (e.g., white, Black) or continentally-defined geographic ancestral clusters (e.g., Africans, Asians, and Europeans)[4,5,7–11,13,16,23]; and

Whereas, Many clinical calculations that "correct for race" were developed under the mistaken belief that race is a useful proxy for intrinsic biological or genetic traits[11,13,14];and

Whereas, Spirometric pulmonary function tests (PFTs) guidelines currently recommending a race-based correction factor despite a 2013 literature review demonstrating that 94% of articles comparing PFTs between white and non-white groups do not assess confounders like socioeconomic status[14,17,18,24]; and

Whereas, Current literature demonstrates that use of race in clinical score calculators is unnecessary, less precise than biological measures, and leads to results that are not reproducible, as evidenced by the use of race in the calculation of estimated glomerular filtration rate (eGFR) based on a 1999 study of 1,628 patients (only 12% of whom self-identified as "Black")[14,19–21,25,26]; and

Whereas, Because the use of race in clinical algorithms reifies racial essentialism and can disproportionately harm Black patients, leading institutions around the country have discarded race-based reporting of eGFR and key stakeholders in the nephrology field are actively working to eliminate this practice in lieu of non-race-based alternatives[13,19–21,27–31]; and

Whereas, Clinical tests and criteria that use race-based factors often do not account for the existence of people from multiracial backgrounds, a population that now makes up 14% of infants born in the US, and other underserved populations including American Indians and Alaskan Natives[13,22,32]; and

Whereas, Current AMA policy supports "research into the use of methodologies that allow for multiple racial and ethnic self-designations" and encourages applying research evidence on race, ethnicity, and health to "the planning and evaluation of health services" (H-460.924); and

Whereas, Perpetuating the incorrect belief that race by itself can explain biological variation contributes to tangible inequities, such as the undertreatment of pain due to wrongly perceived biological differences in pain tolerance, delays in referral for renal transplantation, under-referral for DEXA scans, industry denial of worker's compensation, and more[11,13,14,21,33–36]; and

Whereas, Although racial essentialism is harmful and has no scientific validity, teaching trainees about and researching race as a sociopolitical construct is useful to understand structural racism as a root cause of health inequity, the lived experiences of patients which contribute to their relationship with the healthcare system, and the day-to-day experiences which affect individual health outcomes[3,10–12,37–42]; and

Whereas, Since race and racism impact multiple structural and social determinants of health, there is no easy replacement risk factor, which highlights the need for directed research to uncover the true causal pathways mitigating racial differences in disease prevalence and health outcomes[10,11,20,21,23,40–43]; and

Whereas, Our AMA denounces practices which exacerbate health disparities, serves as a leading voice for marginalized minority groups, and "encourages investigators to recognize the limitations of current methods for classifying race" (H-65.963, H-460.924), but current policy does not identify or explicitly discourage the inappropriate practice of using race as a proxy for biological risk factors; and

Whereas, In June 2020, our AMA Board of Trustees publicly recognized racism as an urgent threat to public health and resolved to "actively work to dismantle racist and discriminatory policies and practices across all of health care"[44;] and

Whereas, In September 2020, the U.S. House Ways & Means Committee released a series of letters which called upon medical societies, including the AMA, to "describe how racism has influenced the use of race in medicine, science, and research, and call for a new path forward where medicine considers race as a tool to measure racism, not biological differences" letter[45]; and

Whereas, In September 2020, lawmakers requested the Agency for Healthcare Research and Quality to conduct a review of clinical algorithms that correct for race and investigate the impact of structural racism on the health of communities of color to advance data-driven, antiracist health policy[46,47]; therefore be it

RESOLVED, That our American Medical Association recognize that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors (Directive to Take Action); and be it further

RESOLVED, That our AMA support research that promotes antiracist strategies to mitigate algorithmic bias in medicine. (Directive to Take Action)

Fiscal Note: Estimated cost of $25,000 to implement resolution.

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RELEVANT AMA POLICY

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 Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
Citation: BOT Action in response to referred for decision Res. 602, I-15;

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Citation: Res. 001, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(November 2020)

Introduced by: Minnesota

Subject: Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research, and Clinical Practice

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Race is a category often used in medicine--with health statistics often stratified by race, research noting how rates of morbidity and mortality vary by race, and clinicians making treatment and other care-related decisions based on the race of a patient; and

Whereas, Following the completion of the Human Genome Project in 2003[i], leading geneticists concluded that race is neither a rational nor effective representation of real human biological variability; and

Whereas, The Human Genome Project also found that people can have greater genetic similarity to those outside their racial category than to those within their racial category, which demonstrates that genetic variation does not follow along racial lines; and

Whereas, Race is a social construct that is a politically developed classification system based on physical characteristics and geographic ancestry and is not based on science and does not represent shared genetic ancestry; and

Whereas, Using race as a proxy for genetics and genetic ancestry allows for harmful continuations of racial ideology and has the potential to negatively impact patient care, such as attributing higher incidences of certain diseases or conditions seen among certain racial groups that may be due to socioeconomic, environmental, and other nongenetic factors--and not their racial category[ii]; and

Whereas, Since race is not biological, there is no value in attributing racial health disparities to innate biological difference, but there is value in understanding how racism and systemic oppression result in racial health disparities; and

Whereas, Epigenetics is the study of changes in gene expression that are not due to changes in the genetic code itself, and racial trauma, stress, discrimination and systemic racist practices, such as financial and environmental disinvestment in minority communities, have been proposed as an etiology of epigenetic changes; and

Whereas, When we use race as a substitute for genetic ancestry, it limits us from investigating and addressing racism and other racial traumas as the cause of racial health disparities; and

Whereas, The way physicians and other health care workers think and talk about race, racism and racial health disparities affects how we treat our patients; and

Whereas, Existing AMA policy E-8.5, "Disparities in Health Care," says, in part, "Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations."[iii]; therefore be it

RESOLVED, That our American Medical Association recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology (New HOD Policy); and be it further

RESOLVED, That our AMA support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice (New HOD Policy); and be it further

RESOLVED, That our AMA encourage undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change[iv] that: (1) demonstrates how the category "race" can influence health outcomes; (2) that supports race as a social construct and not a biological determinant and (3) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/11/20

RELEVANT AMA POLICY

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

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

Issued: 2016

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[iii] AMA Code of Medical Ethics E-8.5 Disparities in Health Care, 2017
[iv] APA Nieblas-Bedolla, Edwin MPH; Christophers, Briana; Nkinsi, Naomi T.; Schumann, Paul D.; Stein, Elizabeth Changing How Race Is Portrayed in Medical Education, Academic Medicine: May 5, 2020 - Volume Publish Ahead of Print - Issue -doi: 10.1097/ACM.0000000000003496