

## **Reference Committee on Amendments to Constitution and Bylaws**

### **BOT Report(s)**

- 17\* Specialty Society Representation in the House of Delegates - Five-Year Review

### **CC&B Report(s)**

- 01\* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs
- 02\* AMA Women Physicians Section: Clarification of Bylaw Language
- 03\* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

### **CEJA Report(s)**

- 01\* CEJA's Sunset Review of 2011 House Policies
- 02\* Short-term Medical Service Trips
- 03\* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"

### **Report of the Speakers**

- 02 Report of the Election Task Force

### **Resolution(s)**

- 001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)
- 002 Sharing Covid-19 Resources
- 003\* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions
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- 006\* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients
- 007\* Nonconsensual Audio/Video Recording at Medical Encounters
- 008\* Organ Transplant Equity for Persons with Disabilities
- 009\* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties
- 010\* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses
- 011\* Truth, Reconciliation and Healing in Medicine and Medical Education
- 012\* Increasing Public Umbilical Cord Blood Donations in Transplant Centers
- 013\* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 014\* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 015\* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals
- 016\* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 017\* Improving the Health and Safety of Sex Workers
- 018\* LGBTQ+ Representation in Medicine
- 019\* Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 020\* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 021\* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-JUN-21

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

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1 The Board of Trustees (BOT) has completed its review of the specialty organizations and the  
2 professional interest medical association seated in the House of Delegates (HOD) scheduled to  
3 submit information and materials for the 2021 American Medical Association (AMA) Annual  
4 Meeting in compliance with the five-year review process established by the House of Delegates in  
5 Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty  
6 Societies," Policy G-600.022 "Admission of Professional Interest Medical Associations to our  
7 AMA House" and AMA Bylaw 8.5, "Periodic Review Process." Although the 2021 Annual  
8 Meeting has been suspended by action of the Board of Trustees, to maintain a consistent review  
9 process the Board completed this review to be presented at the June 2021 Special Meeting of the  
10 House of Delegates.

11  
12 Organizations are required to demonstrate continuing compliance with the guidelines established  
13 for representation in the HOD. Compliance with the five responsibilities of national medical  
14 specialty organizations and professional interest medical associations is also required as set out in  
15 AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional  
16 Interest Medical Associations."

17  
18 The following organizations were reviewed for the 2021 Special Meeting:

19  
20 AMDA – The Society for Post-Acute and Long-Term Care Medicine  
21 American Academy of Child and Adolescent Psychiatry  
22 American Association of Clinical Endocrinology  
23 American Association of Physicians of Indian Origin  
24 American College of Medical Genetics and Genomics  
25 American College of Radiation Oncology  
26 American Institute of Ultrasound in Medicine  
27 American Orthopaedic Foot and Ankle Society  
28 American Society for Clinical Pathology  
29 American Society of Anesthesiologists  
30 American Society of Cataract and Refractive Surgery  
31 American Society of Colon and Rectal Surgeons  
32 American Society of Dermatopathology  
33 American Society of Neuroradiology  
34 Obesity Medicine Association  
35 Renal Physicians Association  
36 Society of Critical Care Medicine  
37 Society of Interventional Radiology

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 and professional medical interest association 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: AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations and profession interest medical associations represented in the HOD.

#### RECOMMENDATIONS

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

1. That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

Fiscal Note: Less than \$500

**APPENDIX*****Exhibit A - Summary Membership Information***

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
AMDA – The Society for Post-Acute and Long-Term Care Medicine	564 of 2,561 (22%)
American Academy of Child and Adolescent Psychiatry	1,186 of 7,033 (17%)
American Association of Clinical Endocrinology	541 of 2,547 (21%)
American Association of Physicians of Indian Origin	1,687 of 12,049 (14%)
American College of Medical Genetics and Genomics	339 of 687 (49%)
American College of Radiation Oncology	267 of 724 (37%)
American Institute of Ultrasound in Medicine	918 of 4,406 (20%)
American Orthopaedic Foot and Ankle Society	212 of 889 (24%)
American Society for Clinical Pathology	1,948 of 7,584 (26%)
American Society of Anesthesiologists	7,001 of 44,293 (16%)
American Society of Cataract and Refractive Surgery	1,013 of 4,088 (25%)
American Society of Colon and Rectal Surgeons	685 of 2,738 (25%)
American Society of Dermatopathology	336 of 1,124 (30%)
American Society of Neuroradiology	1,017 of 4,771 (21%)
Obesity Medicine Association	402 of 1,959 (20%)
Renal Physicians Association	481 of 2,078 (23%)
Society of Critical Care Medicine	1,404 of 6,918 (20%)
Society of Interventional Radiology	679 of 3,271 (21%)

***Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies and Professional Interest Medical Associations (Policies G-600.020 and G-600.022)***

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.

G-600.022

Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA.
2. The organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association).
3. The organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the 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 our AMA; or (iii) that the organization 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 our 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 the profession 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 meet 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.** 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-JUN-21

Subject: Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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During 2020, the five-year transition from dual accreditation entities acknowledged in the AMA Bylaws (ACGME for allopathic physicians and AOA for osteopathic physicians) to a single accreditation entity for all was completed. The ACGME now serves as the nation's sole accreditor for both osteopathic (DO) and allopathic (MD) residencies and fellowships.

The Council has prepared this report with appropriate bylaw amendments to ensure that the AMA Constitution and Bylaws remains an accurate document.

### 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.

**7.1 Resident and Fellow Section.** The Resident and Fellow Section is a fixed Section.

**7.1.1 Membership.** All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

**7.1.1.1 Definition of a Resident.** For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

- a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.
- b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
- c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

**7.1.1.2 Definition of a Fellow.** For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

- 1 a) Members who are serving in fellowships approved by the Accreditation Council for
- 2 Graduate Medical Education ~~or the American Osteopathic Association.~~
- 3 b) Members who are serving, as their primary occupation, in a structured clinical,
- 4 educational, vocational, or research training program of at least six months to broaden
- 5 competency in a specialized field.
- 6

7 (Modify Bylaws)

Fiscal Note: Less than \$500

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-JUN-21

Subject: AMA Women Physicians Section: Clarification of Bylaw Language

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 In 2013, the Board of Trustees Women Physicians Advisory Committee transitioned to the Women  
2 Physicians Section (WPS). The Council has worked closely with the WPS since its inception and  
3 developed the existing bylaw language. The Council also has reviewed several iterations of the  
4 WPS Internal Operating Procedures that were approved by the Board in 2013 and in 2017.

5  
6 The IOP states that “all female physician and medical student members of the AMA as identified in  
7 the AMA Masterfile are automatically enrolled in the WPS.” The IOP further provides the  
8 opportunity for any other AMA member to opt-in as a WPS member. However, AMA Bylaw  
9 7.10.1, states that “all female physicians and medical students who are active members of the AMA  
10 shall be eligible to be members of the Women Physicians Section.” Per Bylaw 7.10.11, “Other  
11 active AMA members who express an interest in women’s issues shall be eligible for WPS  
12 membership.” The subtle distinction is that according to the Bylaws, all AMA member female  
13 physicians and students are “eligible” to join, whereas the IOP includes them “automatically”. The  
14 WPS Governing Council has asked the Council to consider proposing changes to Bylaw 7.10.1.

15  
16 The WPS believes the IOP language better reflects the intent of the House when it created the  
17 section and supports the existing practice of automatically enrolling all AMA member female  
18 physicians as WPS members. The Council on Constitution and Bylaws concurs and presents this  
19 report for House action.

### 20 21 RECOMMENDATIONS

22  
23 The Council on Constitution and Bylaws recommends: 1) that the following amendments to the  
24 AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the  
25 affirmative vote of two-thirds of the members of the House of Delegates present and voting.

26  
27 **7.10 Women Physicians Section.** The Women Physicians Section is a delineated Section.

28  
29 **7.10.1 Membership.** All female physicians and medical students who are active  
30 members of the AMA shall be ~~eligible to be~~ members of the Women  
31 Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express  
32 an interest in women’s issues shall be eligible to join the section. (Modify  
33 Bylaws)

Fiscal Note: Less than \$500

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-JUN-21

Subject: Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 The suspension of the 2020 Annual Meeting led to questions about eligibility for election within  
2 the Young Physicians Section, and the Council on Ethical and Judicial Affairs suggested that the  
3 Council on Constitution and Bylaws clarify the language of Bylaw 7.5.2 to more clearly explain  
4 when a YPS governing council member's eligibility to remain in office. Per Bylaw 6.5.2.2, CEJA  
5 has responsibility for interpreting the Constitution, Bylaws and rules of the AMA.

6  
7 Bylaw 7.5.2 states: "If any officer or Governing Council member ceases to meet the membership  
8 requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such  
9 officer or member shall terminate and the position shall be declared vacant. If any officer's or  
10 member's term would terminate prior to the conclusion of an Annual Meeting, such officer or  
11 member shall be permitted to serve in office until the conclusion of the Annual Meeting in the  
12 calendar year in which such officer or member ceases to meet the membership requirements of  
13 Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA.  
14 The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately  
15 preceding provision of this section, the Immediate Past Chair shall be permitted to complete the  
16 term of office even if the Immediate Past Chair is unable to continue to meet all of the membership  
17 requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the  
18 AMA."

19  
20 Bylaw 7.5.1, defines YPS Membership as "All active physician members of the AMA who are not  
21 resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of  
22 professional practice after residency and fellowship training programs."

23  
24 In preparing this report, the Council stresses that its intent is to clarify existing language consistent  
25 with prior House action.

### 26 27 BACKGROUND

28  
29 When the Young Physicians Section was established in 1986, YPS membership was defined as  
30 physicians under the age of 40 or within the first five years of professional practice. The Bylaws at  
31 that time stated that any physician who met the criteria for section membership was eligible to run  
32 for office but would need to resign if for any reason the individual ceased to be a member of the  
33 section. An additional provision provided specificity about how the chair-elect served a one-year  
34 term, then automatically assumed the chair position for another year and ultimately moved into the  
35 immediate past chair position for a total of 3 years of service. At all times, that individual was  
36 required to meet the definition of young physician.

Over the ensuing years, the House adopted several bylaw amendments, notably:

- Language allowing the immediate past chair to serve even if he/she no longer is considered a young physician [CCB Report E, A-92]
- A grace period for governing council members (except the chair-elect) whose eligibility for YPS membership ends in the months preceding an Annual Meeting [CCB Report 4, I-03]
- Redefining a young physician as under age 40 or within the first 8 years of professional practice [CCB Report 2, A-07]

## DISCUSSION

The current language of 7.5.2 dates from 1992 and is a bit confusing as it pertains to who can run for and hold the positions of chair-elect, chair and immediate past chair, which is what brought the issue to CEJA's attention.

Historical bylaw language stating that the chair-elect to immediate past chair progression entailed a total of 3 years of service was eliminated in 2006 when the Bylaws were simplified by consolidating many provisions and removing others from the Bylaws into individual section internal operating procedures [CCB Report 2, A-06]. Initially, the physician elected to the chair-elect position was required to meet the definition of 'young physician' for the entire 3-year term. Over time, the House provided an exemption for any chair (or other governing council member with the exception of the chair-elect) who reached the age of 40 or the maximum years in practice in the calendar year in which YPS elections occur to serve out the term. The House later added an additional grace provision to allow an immediate past chair to fulfill the 3-year commitment despite attaining age 40 or reaching the maximum years in practice.

Current Bylaw 7.5.2 as written and taken in accord with other bylaw language, which stipulates that all governing council members must be eligible for YPS section membership, prohibits a young physician from running for the chair-elect position if that individual will "age" or "term out" at any time during a chair-elect year, hence the wording "The preceding provision shall not apply to the Char-Elect." Other language ("If any officer's ... term would terminate prior to the conclusion of an Annual Meeting, such officer ... shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1..." allows the chair to serve a full year as YPS chair if the birthday or time in practice component of the eligibility criteria occurs between January and June. If, however, the birthday or years in practice occurs between June and year-end, the individual is not allowed to complete the term and must vacate the office. All chairs who complete the chair term may progress to the immediate past chair position regardless of age or time in practice, thus the language "Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA."

Several other bylaws impact the language of 7.5.2:

**7.0.3 Governing Council.** There shall be a Governing Council for each Section to direct the programs and the activities of the Section. The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.

**7.0.3.1 Qualifications.** Members of each Section Governing Council must be members of the AMA and of the Section.

**7.0.4 Officers.** Each Section shall select a Chair and Vice Chair or Chair-Elect and other necessary and appropriate officers.

**7.0.4.1 Qualifications.** Officers of each Section must be members of the AMA and of the Section.

As requested by CEJA, the Council has developed the following amended bylaw language which it believes more clearly states the requirements:

**7.5 Young Physicians Section.** The Young Physicians Section is a fixed Section.

**7.5.1 Membership.** All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

**7.5.2 Cessation of Eligibility of Governing Council Members.** If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

**7.5.2.1** The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2<sup>nd</sup> year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

## 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.

**7.5 Young Physicians Section.** The Young Physicians Section is a fixed Section.

**7.5.1 Membership.** All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

**7.5.2 Cessation of Eligibility of Governing Council Members.** If any ~~officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw

7.5.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If any officer's or member's term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. ~~The preceding provision shall not apply to the Chair Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.~~

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2<sup>nd</sup> year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

(Modify Bylaws)

Fiscal Note: Less than \$500



## REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 1-JUN-21

Subject: CEJA's Sunset Review of 2011 House Policies

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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- 1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of  
2 American Medical Association policies to ensure that our AMA's policy database is current,  
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and  
4 specifying the needed procedures:  
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A  
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to retain  
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset  
9 the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.  
10
- 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies  
13 that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to  
14 the appropriate AMA councils for review; (c) Each AMA council that has been asked to review  
15 policies shall develop and submit a report to the House of Delegates identifying policies that are  
16 scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one  
17 of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or  
18 (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it  
19 makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent  
20 justification (f) The Speakers shall determine the best way for the House of Delegates to handle the  
21 sunset reports.  
22
- 23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier  
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or  
25 has been accomplished.  
26
- 27 4. The AMA councils and the House of Delegates should conform to the following guidelines for  
28 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been  
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is  
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of  
31 Delegates Reference Manual: Procedures, Policies and Practices.  
32
- 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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

1 6. Sunset policies will be retained in the AMA historical archives.  
2

3 RECOMMENDATION  
4

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

Fiscal Note: Less than \$500.

## APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
<a href="#">D-140.980</a>	Pending Federal Executions	Our AMA immediately inquire whether federal executions involve physicians, and if physicians are involved, that our AMA communicate to the federal government that such physician participation violates fundamental ethical standards of the medical profession and that other appropriate means be substituted that do not require physician participation. (Res. 9, A-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; still relevant but superseded by more recent policy: <a href="#">H-140.898</a> Medical Profession Opposition to Physician Participation in Execution; <a href="#">9.7.3</a> Capital Punishment Code of Medical Ethics; <a href="#">D-140.991</a> Continuing Efforts to Exclude Physicians from State Executions Protocols; <a href="#">H-140.963</a> Secrecy and Physician Participation in State Executions
<a href="#">D-315.988</a>	Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry	Our AMA will (1) work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows: (a) implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements; (b) communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf; and (c) work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice; and  <del>(2) assume a leadership position in both developing a</del> <u>Support continued updating of</u> Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct, <del>and in convening representatives from HIOs and the pharmaceutical companies to promulgate the adoption of the code of conduct in the use of prescribing data.</del> (BOT Rep. 24, I-04; Reaffirmed in lieu of Res. 624, A-05; Reaffirmation A-09; Reaffirmed: Res. 233, A-11)	Rescind in part.  (1) Remains relevant  (2) Remains relevant, though a guide for interaction has been developed (can be found <a href="#">here</a> ). Language amended as shown to reflect continued support of guidance.

<a href="#">D-350.991</a>	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	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)	Rescind in light of the dissolution of the Commission to End Health Care Disparities; initiatives of the newly launched Center for Health Equity, and; superseded by policies adopted in 2019 and 2020: <a href="#">H-65.953</a> Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice; <a href="#">D-350.981</a> Racial Essentialism in Medicine; <a href="#">H-65.952</a> Racism as a Public Health Threat; <a href="#">H-350.974</a> Racial and Ethnic Disparities in Health Care
<a href="#">D-435.995</a>	Medical Care Online	Our AMA will educate physicians to be aware of clauses in their professional liability insurance coverage which may require them to report changes or additions to their practice-related activities, including the use or sponsorship of Web sites, e-mail, Internet discussion groups, and mailing lists. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
<a href="#">H-120.991</a>	Sample Medications	Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge; (2) reiterates that samples of prescription drug products represent valuable benefits to the patients; (3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and (4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription	Retain; remains relevant

		drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples. (Sub. Res. 17, I-86; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: Res. 516, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
<a href="#">H-140.850</a>	Exhibition of Plasticized Bodies Without Known Informed Consent	Our AMA will request that the United States or international authorities investigate if the bodies for the Premier Exhibition Inc. "Bodies Revealed" exhibits were obtained according to international human rights norms. (Res. 7, A-11)	Rescind; accomplished. Per June 2012 Implementation Chart: A letter signed by Dr. Madara was sent on September 22, 2011 requesting the Department of State - Bureau of Democracy, Human Rights, and Labor to participate in a thorough investigation of the manner in which plasticized remains have been obtained to assure that international human rights norms, including informed consent for the donation, have been followed.
<a href="#">H-140.901</a>	Equity in Health Care for Domestic Partnerships	Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee. (Res. 101, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
<a href="#">H-140.964</a>	Enforcement of Code of Ethics	It is the policy of the AMA (1) to make appropriate education and enforcement of its ethical guidelines a priority and (2) with the input and consent of the Federation, to begin a process to coordinate the Federation, including specialty societies and hospital medical staffs, in joint efforts to better communicate and enforce ethical standards. (BOT Rep. BBB, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
<a href="#">H-140.967</a>	Conflicts of Interest	Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of	Retain; remains relevant.

		ethics. (CEJA Rep. G, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
<a href="#">H-245.969</a>	Opposing Legal Prohibition of Circumcision	Our AMA will oppose any attempt to legally prohibit male infant circumcision. (Res. 222, I-11)	<p>Rescind; more recent policy better captures the nuances of supporting male infant circumcision: <a href="#">H-60.945</a></p> <p>Neonatal Male Circumcision, which reads:</p> <p>1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.</p> <p>2. Our AMA encourages state</p>

			Medicaid reimbursement of neonatal male circumcision.
<a href="#">H-275.976</a>	Boundaries of Practice for Health Professionals	<p>(1) The health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services required by an individual patient are provided by a professional whose basic competence and current performance are suited to render those services safely and effectively. In addition, patients also have a responsibility for maintaining coordination and continuity of their own health care.</p> <p><del>(2) As a supplement to strengthen state licensure of health professionals, standard setting and self-regulatory competency assurance programs should be conducted by health professions associations, certifying and accrediting agencies, and health care facilities. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 8, A-11)</del></p>	<p>Retain in part.</p> <p>Retain (1); remains relevant.</p> <p>Rescind (2); superseded by more recent policy <a href="#">H-300.982</a> Maintaining Competence of Health Professionals, which reads in part: (1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such</p>

			standards should be reviewed and revised periodically.
<a href="#">H-285.910</a>	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	<p>Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:</p> <p><b>Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community</b></p> <p>In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.</p> <p>(Res. 8, A-11)</p>	Retain; remains relevant.
<a href="#">H-350.972</a>	Improving the Health of Black and Minority Populations	<p>Our AMA supports:</p> <p>(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.</p> <p>(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.</p> <p>(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.</p> <p>(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early</p>	Retain; remains relevant.



		diagnosis. (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)	
<a href="#">H-375.984</a>	<u>Participation in Peer Review</u>	Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: BOT Rep. 13, I-11)	Retain; remains relevant. Title amended for clarity of content.
<a href="#">H-375.989</a>	Protection of Peer Review Records in Litigation	Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11)	Rescind; superseded by more recent and encompassing policy <a href="#">H-375.962</a> Legal Protections for Peer Review, particularly: <b>Privilege.</b> The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

			<b>Confidentiality.</b> Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.
<a href="#">H-375.993</a>	Confidentiality in Medical Staff Peer Review	Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 13, I-11)	<p>Rescind; superseded by more recent and encompassing policy <a href="#">H-375.962</a> Legal Protections for Peer Review, particularly:</p> <p><b>Composition of the Peer Review Committee</b></p> <p>Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.</p>
<a href="#">H-375.997</a>	Voluntary Medical Peer Review	Our AMA advocates the following principles for voluntary medical peer review: (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.	Retain; remains relevant.

		<p>(2) Medical peer review should be a local process.</p> <p>(3) Physicians should be ultimately responsible for all peer review of medical care.</p> <p>(4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review.</p> <p>(5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.</p> <p>(6) Any system of medical peer review should have established procedures.</p> <p>(7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation.</p> <p>(8) Peer review should be an educational process for physicians to assure quality medical services.</p> <p>(9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 5, I-10; Reaffirmed: BOT Rep. 13, I-11)</p>	
<a href="#">H-405.978</a>	Physicians with Communicable Diseases	Our AMA supports the development of general and specific recommendations relating to provision of patient care by physicians infected with communicable diseases of all types. (Res. 222, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant. This policy aligns with recently adopted policy on immunizations by physicians: <a href="#">8.7</a> Routine Universal Immunization of Physicians, modified 2020, reads in part “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... including refraining from direct patient contact when appropriate.” <a href="#">H-440.831</a> Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization has similar language regarding practice adjustments.
<a href="#">H-420.954</a>	Truth and Transparency in Pregnancy Counseling Centers	<p>1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further</p> <p>2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws. (Res. 7, I-11)</p>	Retain; remains relevant.
<a href="#">H-440.946</a>	Health Care Workers and HBV - Nonresponders to HBV Vaccine	<p>It is the policy of the AMA that (1) health care workers who practice invasive procedures and who have been immunized with HBV vaccine be tested for evidence of immunity as determined by a protective anti-HBs level (as currently defined by the United States Public Health Service) one to six months after the completion of an immunization series;</p> <p>(2) such health care workers who fail to respond with an adequate anti-HBs level be counseled about their immune status, its possible impact on their careers, and offered a complete revaccination series;</p> <p>(3) health care workers given a revaccination series be tested again for an adequate anti-HBs level one to six months following the completion of the immunization series. Those who again fail to respond with a protective level should be counseled about the need to continue to follow universal precautions and the risk to their health if they continue to perform invasive procedures; and</p> <p>(4) health care workers be encouraged to maintain HBV immunity by obtaining</p>	Rescind; purpose and intent covered in <a href="#">H-405.978</a> Physicians with Communicable Diseases.

		appropriate booster immunization when indicated. BOT Rep. X, I-91Reaffirmed: Sunset Report, I-01Reaffirmed: CEJA Rep. 8, A-11	
<a href="#">H-440.949</a>	Immunity to Hepatitis B Virus	It is the policy of the AMA that a health care worker who is at risk for HBV infection, has no immunity resulting from a natural infection, and who has not initiated immunization with HBV vaccine, either be immunized or should abstain from performing invasive procedures. (BOT Rep. CCC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; purpose and intent covered in <a href="#">H-405.978</a> Physicians with Communicable Diseases.
<a href="#">H-460.906</a>	Enhancing Patient Awareness of Research Participation	Our AMA: 1) will work with relevant health professional associations, patient groups, and the National Institutes of Health to encourage physicians to promote increased awareness among their patients, those who are healthy as well as those with specific diseases or conditions, of the societal and public health benefits of, and opportunities for, research participation; and 2) encourages physicians to participate in practice-based research initiatives and to enroll in practice-based research networks. (Res. 521, A-11)	Retain; remains relevant.
<a href="#">H-460.924</a>	Race and Ethnicity as Variables in Medical Research	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. (CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by recent policy adopted at N-20. See <a href="#">H-65.953</a> Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, <a href="#">D-350.981</a> Racial Essentialism in Medicine

<a href="#">H-460.954</a>	Researchers Lending Their Names as Co-authors of Laboratory Findings in Which They Did Not Participate	Our AMA condemns the practice of those persons who permit their names to be used as co-authors of papers publishing laboratory findings in which they did not participate, noting that persons who engage in such practice bear equal responsibility with those who are guilty of falsifying laboratory findings. Our AMA urges editors of scientific journals to reject for publication any paper reporting laboratory findings and research in which any person named as a co-author was not an active participant. (Res. 101, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
<a href="#">H-460.972</a>	Fraud and Misrepresentation in Science	The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)	Retain; remains relevant.
<a href="#">H-5.988</a>	Accurate Reporting on AMA Abortion Policy	Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA	Retain; remains relevant.

		policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy. (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
<a href="#">H-520.987</a>	Condemning the Use of Children as Instruments of War	Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. (Res. 411, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
<a href="#">H-525.987</a>	Surgical Modification of Female Genitalia	Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia. (Res. 13, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	<p>Rescind; superseded by more recent policy as outlined below:</p> <p>In re: infants and children with differences of sex development, see <a href="#">2.2.1 Pediatric Decision Making</a>, specifically (c) “Develop an individualized plan of care...in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become.”</p> <p>In re: female genital mutilation, see <a href="#">H-525.980</a> Expansion of AMA Policy on Female Genital Mutilation, which uses the FGM terminology (rather than broad language of “surgical modification” used in the policy at left). Last updated in 2017 it reads:</p> <p>Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the</p>

			<p>procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.</p>
<a href="#">H-65.978</a>	Nondiscrimination in Responding to Terrorism	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)	Retain; remains relevant.
<a href="#">H-80.995</a>	Evaluation of the Use of DNA Identification Testing in Criminal Proceedings	<del>(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) appropriate control procedures to minimize the adverse effects of contamination and degradation; (b) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (c) the creation and use of population databases which accurately reflect the ethnic composition of</del>	Rescind (1), (2) and (3); these have been accomplished by the Organization of Scientific Area Committees for Forensic Science who develop national forensic science



		<p><del>populations amongst which matches might be sought.</del></p> <p><del>(2) The independent validation of each probe used for DNA identification testing should be conducted.</del></p> <p><del>(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.</del></p> <p><del>(4) DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files. (BOT Rep. FF, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)</del></p>	<p>standards and have <a href="#">published</a> (2020) quality control guidelines that address degradation and DNA probes. The FBI has also <a href="#">published</a> (2020) Quality Assurance Standards for Forensic DNA Testing Laboratories.</p> <p>Retain (4); remains relevant. Numbering removed and title amended as editorial edits.</p>
<a href="#">H-90.987</a>	Equal Access for <del>Physically Challenged</del> Physicians <u>with Physical Disabilities</u>	<p>Our AMA supports equal access to all hospital facilities for <del>physically-challenged</del> physicians <u>with physical disabilities</u> as part of the Americans with Disabilities Act. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)</p>	<p>Retain; remains relevant, with editorial changes in title and body to reflect person-first language.</p>

## REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 2-JUN-21

Subject: Short-term Medical Service Trips

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Short-term medical service trips, which send physicians and physicians in training from wealthier  
2 countries to provide care in resource-limited settings abroad for a period of days or weeks, have  
3 emerged as a prominent strategy for addressing global health inequities. They also provide training  
4 and educational opportunities, thus offering benefit both to the communities that host them and the  
5 medical professionals and trainees who volunteer their time and clinical skills. At the same time,  
6 short-term medical service trips pose challenges for both volunteers and in prioritizing activities to  
7 meet jointly defined goals; navigating day-to-day collaboration across differences of culture,  
8 language, and history; and fairly allocating host and team resources in the local setting.

9  
10 This report by the Council on Ethical and Judicial Affairs (CEJA) explores the phenomenon of  
11 short-term medical service trips and offers guidance for physicians and physicians in training to  
12 help them address the ethical challenges they face in providing clinical care in resource-limited  
13 settings abroad.

### 14 15 THE APPEAL OF SERVING ABROAD

16  
17 Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is  
18 difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3  
19 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically  
20 related [11]. For trainees, in January 2015 the Consortium of Universities for Global Health  
21 identified more than 180 websites relating to global health opportunities [2]. The Association of  
22 American Medical Colleges found that among students who graduated in 2017–2018 between 25%  
23 and 31% reported having had some “global health experience” during medical school [3].

24  
25 A variety of reasons motivate physicians and trainees to volunteer for service trips. For many,  
26 compelling motivations include the opportunities such trips offer to help address health inequities,  
27 to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic  
28 of study [11]. Service trips can also serve less lofty goals of building one's resume and improving  
29 one's professional prospects, gaining the esteem of peers and family, or simply enjoying  
30 international travel [1].

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

## A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including “short-term medical volunteerism” [4], “short-term medical missions” [5], “short-term medical service trips” [6,7], “short-term experience in global health” [8,9], “global health field experience” [10], “global health experience,” and “international health experience”[1]. Each has merit as a term of art.

The Council on Ethical and Judicial Affairs prefers “short-term medical service trips.” In the council’s view, this term is clear, concrete, concise, and does not lend itself to multiple interpretations and possible misunderstanding. Importantly, it succinctly captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

## MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [9]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [8]. Many now also offer training opportunities for medical students and residents [8,9,10]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [8,9].

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are inherently vulnerable, “victims of social, economic, or environmental factors” who have limited access to health care [6]. As one observer noted, those who participate in short-term medical service trips and those who host them “can be characterized, respectively, as ‘people who travel easily and people who do not’” [9]. The latter also often lack access not only to health care, but to food, and economic and political power and “may feel unable to say no to charity in any form offered” [9].

The medical needs of host communities differ from those of volunteers’ home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by “conditions, such as severe malnutrition, for which medical volunteers may have limited experience” [6]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

## ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities of scarcity and vulnerability define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties not only to maximize and enhance good clinical outcomes, but also to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [8,1,9,10].

### *Promoting Justice & Sustainability*

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to

helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [8,6]. Trips should seek to balance community priorities with the training interests and abilities of participants [9], but in the first instance benefits should be those desired by the host community [8]. Likewise, interventions must be acceptable to the community [8].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [6]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [6,9].

#### *Minimizing Potential for Harms & Burdens in Host Communities*

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips could place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [8], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [8,10]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [6].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [10]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [10].

#### *Respecting Persons & Cultures*

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [8,1]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local “explanatory models” of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community [6,9,10].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [10], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities’ cultural and social traditions does *not* obligate physicians and trainees “to violate fundamental personal values, standards of medical care or ethical practice, or the law” [8]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [11]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [12].

## GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip’s overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [8,1,9,10].

### *Prepare Diligently*

Guidelines from the American College of Physicians recognize that “predeparture preparation is itself an ethical obligation” [8,cf. 1]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [10].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who have “training and/or familiarity with principles of international development, social determinants of health, and public health systems” [9].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs,

travel, malpractice insurance, and local credentialing requirements [6]. Equally important, to contribute effectively and minimize “culture shock” and distress, volunteers need a basic understanding of the context in which they will be working [1,6]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [6]. And they need to know whom they can turn to for guidance in the moment.

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real possibility for physicians and trainees that they will encounter situations in which they “are unable to act in ways that are consistent with ethics and their professional values” or “feel complicit in a moral wrong” [8]. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

### *Choose Thoughtfully*

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, by preference choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [8,9,10]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, which can promote dependence on the cycle of foreign charitable assistance rather than development of local infrastructure [9].

### *Measure & Share Meaningful Outcomes*

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [8,6,9]. The measures used to evaluate program outcomes should be appropriate to the program’s goals as defined proactively in collaboration with the host community [8]; for example, some have suggested quality-adjusted life years (QALYs) [13]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [6]. Developing meaningful outcome measures will require thoughtful reflection on the knowledge and skills needed to address the specific situation of the community or communities being served and on what preparations are essential to maximize health benefits and avoid undue harm.

## RECOMMENDATION

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

- (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.
- (b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.
- (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

- (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally
- (e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required

1 to provide acceptable safe, high quality care in the host setting. Team members should  
2 practice only within the limits of their training and skills in keeping with the professional  
3 standards of the sponsor's country.  
4

- 5 (f) Put in place a mechanism to collect data on success in meeting collaboratively defined  
6 goals for the trip in keeping with recognized standards for the conduct of health services  
7 research and quality improvement activities in the sponsor's country.  
8

9 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500



## 1 REFERENCES

- 2
- 3 1. St. Clair NE, Pitt MB, Bakeera-Kitaka S, et al. Global health: preparation for working in
- 4 resource-limited settings. *Pediatrics*. 2017;140(5):e20163783.
- 5 2. Consortium of Universities for Global Health. Cough.org. Accessed January 10, 2020.
- 6 3. Association of American Medical Colleges. *Medical School Graduation Questionnaire 2018*
- 7 *All Schools Summary Report*. Available at
- 8 <https://www.aamc.org/system/files/reports/1/2018gqallschoolssummaryreport.pdf>. Accessed
- 9 October 29, 2019.
- 10 4. DeCamp M. Ethical review of global short-term medical volunteerism. *HEC Forum*.
- 11 2011;23:91–103.
- 12 5. Roche SD, Ketheeswaran P, Wirtz VJ. International short-term medical missions: a systematic
- 13 review of recommended practices. *Int J Public Health*. 2017;62:31–42.
- 14 6. Stone GS, Olson KR. The ethics of medical volunteerism. *Med Clin N Am*. 2016;100:237–246.
- 15 7. Sykes KJ. Short-term medical service trips: a systematic review of the evidence. *Am J Public*
- 16 *Health*. 2014;104:e38–e48.
- 17 8. DeCamp M, Soleymani Lehmann L, Jaehl P, et al. Ethical obligations regarding short-term
- 18 global health clinical experiences: an American College of Physicians position paper. *Ann*
- 19 *Intern Med*. 2018;160:651–657.
- 20 9. Melby MK, Loh LC, Evert J, et al. Beyond medical “missions” to impact-driven short-term
- 21 experiences in global health (STEGHs): ethical principles to optimize community benefit and
- 22 learner experience. *Acad Med*. 2016;91(5):633–638.
- 23 10. Crump JA, Sugarman J. Global health training: ethics and best practice guidelines for training
- 24 experiences in global health. *Am J Trop Med Hyg*. 2010;83(6):1178–1182.
- 25 11. Freedman B. Offering truth: one ethical approach to the uninformed cancer patient. *Arch Intern*
- 26 *Med*. 1983;153:572–576.
- 27 12. American Medical Association. *Code of Medical Ethics*, Opinion 1.1.7, Physician exercise of
- 28 conscience. Available at [https://www.ama-assn.org/delivering-care/ethics/physician-exercise-](https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience)
- 29 [conscience](https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience). Accessed October 29, 2019.
- 30 13. MacAskill W. *Doing Good Better*. New York: Avery, 2015.

## REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 3-JUN-21

Subject: Amendment to Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues”

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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In conjunction with the adoption of the modernized *Code of Medical Ethics* by the American Medical Association House of Delegates in June 2016, several stakeholders raised concerns that the Council on Ethical and Judicial Affairs’ (CEJA) guidance does not clearly distinguish being impaired from having a disability; does not acknowledge that not all illness or disability leads to impairment; and does not clearly address the fact that appropriate rehabilitation or accommodation can enable physicians who are impaired or who have a disability to practice safely.

The following report updates AMA ethics guidance to address these issues.

### ILLNESS, DISABILITY & IMPAIRMENT

[Opinion 9.3.2](#) defines impairment as “[p]hysical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities...” The fact that a physician has a physical or mental health condition does not necessarily entail that the individual is also impaired. As the Federation of State Medical Boards (FSMB) has noted, “impairment is a functional classification” and that “the diagnosis of an illness does not equate with impairment” [1]. This distinction is fundamental to the goals of destigmatizing the conditions that can cause impairment and supporting physicians who become ill or have a disability but are nonetheless capable of safe and effective practice.

Disability leading to impairment has a broad range of meaning as it relates to the ability to practice medicine safely. A variety of physical and mental health conditions (including substance use or conditions related to aging), may result in cognitive or physical changes that can interfere with ability to practice safely. Among physicians, substance use disorder can also be a significant cause of impairment, with some studies showing rates as high as 21% [2]. And while physicians suffer many acute and chronic illness at similar rates to the general public, some illnesses, such as depression, occur with greater prevalence--medical residents, for example, experience depression at a rate of 15-30% compared to 7-8% in the general public [2]. Subtle changes in cognition or motor skills such as those associated with aging are difficult to identify and challenging to interpret with respect to their effect on ability to practice competently and safely. By contrast, sensory or physical disability (blindness, deafness, paraplegia) are often readily identifiable but do not necessarily impair safe practice in selected fields of medicine [1].

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Screening and testing can be important for identifying physicians whose ability to practice at accepted professional standards is compromised by illness or disability. Some experts recommend a multi-pronged approach: mandatory testing before employment, random drug testing, evaluations after a sentinel event like a patient death or medical error, and establishment of uniform, national standards to encourage consistency across jurisdictions [3].

However, testing is not without its own challenges. For example, a seemingly straightforward drug test can produce false positive results in response to a legitimate or prescribed substance, and if handled improperly could “destroy a career” [3]. Further, not all testing produces a definitive result. Tests of cognitive or physical capacity may provide some data, but leave important questions unanswered, such as “When does ‘decline’ become ‘impairment’? And when does ‘impairment’ compromise safety?” [4]. Because impairment is a function of the nature of a physician’s practice, test results must be interpreted in context [5]. Screening and/or testing must be fair and thoughtfully implemented to avoid discrimination. Testing should also balance the need to detect impairment with physicians’ rights to privacy, autonomy, and due process [3].

## RESPONDING TO IMPAIRMENT

Physicians’ fiduciary obligation to patients encompasses responsibilities to maintain their own physical and mental health [Opinion 9.3.1], to cultivate self-awareness as a dimension of professional competence [Opinion 8.13], and a responsibility to respond when they believe a colleague is impaired to the extent patients are at risk, in keeping with the profession’s overarching duty of self-regulation. These obligations are grounded in the principle that physicians “uphold standards of professionalism” in part by responding to other physicians who are “deficient in character or competence” [Principle II].

### *Seeking & Offering Assistance*

Physicians’ responsibility for self-awareness requires that they be sensitive to factors that affect their ability to provide appropriate care, one of which is their own health status. When they become aware that a physical or mental health condition may be interfering with their ability to provide sound patient care, they have a responsibility to address the problem, by consulting their personal physician or seeking other assistance. As CEJA has noted elsewhere,

Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation [CEJA Report 1-I-19].

Physicians are professionally responsible to one another and thus have an obligation to respond when a colleague appears to be unable to practice safely. They should intervene with respect and compassion to ensure, first, that the individual no longer endangers patients, and second, that the individual receives appropriate evaluation and care to treat any impairing condition.

### *Intervention*

Ultimately, physicians have an ethical duty to act when colleagues continue to practice unsafely despite efforts to dissuade them, including reporting where appropriate and needed. This responsibility derives from the obligation of self-regulation, a central element of the medical

profession's contract with society to establish and uphold standards of competence and conduct for safe, ethical and effective patient care" [6] In some situations, physicians may have a legal duty to report colleagues whom they believe may be impaired [7].

A host of factors can complicate the duty to report, including not only uncertainty about whether impairment is actually present, but also denial, stigmatization, concerns about practice coverage, and fear of retaliation (especially when reporting a superior) [7]. Health care institutions and state medical boards should offer education and training to help physicians be more effective and comfortable with detecting impairment in the workplace. Fostering an environment where physicians know what to look for and feel comfortable reporting helps protect the well-being of all parties involved. Early detection mitigates harm by catching an impairment before it worsens and creates a less safe practice environment over time [4].

#### ACCOMMODATING DISABILITY

The 1990 Americans with Disabilities Act (ADA) ushered in a new era of legal protections and rights for people with disabilities, and its impact in creating opportunity and support is felt in health care as elsewhere. An increasing number of physicians with disabilities who are practicing medicine today represent the "ADA generation," individuals who, prior to the legal protections afforded by the ADA, would have been deterred from pursuing a career in medicine [8].

While accommodations that provide physicians with disabilities the opportunity to practice medicine help to ensure a more safe and equitable practice environment for physicians with disabilities, such accommodations also offer benefits more broadly to the patients they serve and by extension can strengthen the patient-physician relationship. Experts recognize that concordance between patients and physicians with disability is key in enhancing quality of care, noting that "increasing the number of physicians who actively identify as having a disability and who require accommodations to practice could improve health care experiences and outcomes for patients with disabilities", as they are better able to "provide patient-centered care" with greater empathy [9, 10]. Removing barriers to practice, when and where they are unnecessary, is ethically required and promotes a more just and diverse workforce [11]. Diversity is essential to combating bias and building empathy; as Ouellette succinctly notes: "one way to counter bias against outsiders [disabled patients] is to make them insiders [physicians]" [10].

Removing barriers should extend to those who seek to enter the profession as well. Technical standards—criteria for medical school admission that require applicants to "demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance" (emphasis added) [12], create a fundamental barrier for prospective medical students. Experts argue that medical schools should adjust their technical standards from an approach that focuses on students' limitations to a functional approach that focuses on "students' abilities with or without the use of accommodations or assistive technologies" [12] Making such an adjustment is a fundamental step to creating a more inclusive medical profession to the benefit of all. Though there is much work still to be done, the available data suggest that individuals with disability are increasingly successful in becoming educated and trained in medicine. More physicians with disability now enjoy successful careers in medicine [8,13]. Barriers to practice are often "attitudinal or cultural in nature," not barriers born from a valid foundation of safe medical practice [13].

#### RETURN TO SAFE PRACTICE

Physicians who have undergone successful treatment for an impairing condition or received an accommodation that enables the physician to practice safely should have the right and the

1 opportunity to practice medicine again. Data has demonstrated, that with proper treatment and help,  
2 physicians can successfully recover and return to practice [7,14].  
3

4 A 2013 report by the FSMB offered guidance for state boards and physician health programs  
5 regarding re-entry to practice by impaired physicians [15]. Those recommendations provide for:  
6

- 7 • Case by case review informed by FSMB's Policy on Physician Impairment,
- 8 • A re-entry plan modeled on the 2012 FSMB guide on re-entry that addressed matters of timing  
9 of re-entry, barriers, and common terminology [16].  
10

## 11 CONCLUSION

12

13 Physician impairment can be the result of any illness or condition - physical or mental. In the  
14 interest of patient safety and to meet the profession's ethical obligation of self-regulation, it is  
15 important for physicians to be self-aware and sensitive to pressures of training and practice  
16 environments and be prepared to respond when signs of impairment are observed, both in  
17 themselves and their colleagues. Impaired physicians should receive the intervention and treatment  
18 needed and be given the opportunity to rehabilitate and reenter practice safely. Physicians should  
19 also be mindful that not all disability and illness cause impairment.  
20

21 Society, health care systems, educational and training institutions, and practice environments must  
22 continue, where possible, to accommodate the needs of all physicians, including those with  
23 identified illness and disability. Medical schools should be encouraged to have technical standards  
24 that allow for students with non-impairing disabilities to enter the profession. Society and the  
25 profession must also have effective mechanisms in place to recognize and respond to physician  
26 impairment, in the interest of patient safety and meeting the needs to colleagues who can and want  
27 to be rehabilitated and reenter practice. The goal should be that with appropriate care or  
28 accommodations a physician will ultimately be able to return to practice safely and effectively, if  
29 possible.  
30

## 31 RECOMMENDATION

32

33 The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician  
34 Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues  
35 with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder  
36 of this report be filed:  
37

38 Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote  
39 patient welfare. Yet a variety of physical and mental health conditions—including physical  
40 disability, medical illness, and substance use—can undermine physicians' ability to fulfill that  
41 obligation. These conditions in turn can put patients at risk, compromise physicians'  
42 relationships with patients, as well as colleagues, and undermine public trust in the profession.  
43

44 While some conditions may render it impossible for a physician to provide care safely, with  
45 appropriate accommodations or treatment many can responsibly continue to practice, or resume  
46 practice once those needs have been met. In carrying out their responsibilities to colleagues,  
47 patients, and the public, physicians should strive to employ a process that distinguishes  
48 conditions that are permanently incompatible with the safe practice of medicine from those that  
49 are not and respond accordingly.

1 As individuals, physicians should:

- 2
- 3 (a) Maintain their own physical and mental health, strive for self-awareness, and promote
- 4 recognition of and resources to address conditions that may cause impairment.
- 5
- 6 (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping
- 7 with ethics guidance on physician health and competence.
- 8
- 9 (c) Intervene with respect and compassion when a colleague is not able to practice safely.
- 10 Such intervention should strive to ensure that the colleague is no longer endangering
- 11 patients and that the individual receive appropriate evaluation and care to treat any
- 12 impairing conditions.
- 13
- 14 (d) Protect the interests of patients by promoting appropriate interventions when a colleague
- 15 continues to provide unsafe care despite efforts to dissuade them from practice.
- 16
- 17 (e) Seek assistance when intervening, in keeping with institutional policies, regulatory
- 18 requirements, or applicable law.
- 19

20 Collectively, physicians should nurture a respectful, supportive professional culture by:

- 21
- 22 (f) Encouraging the development of practice environments that promote collegial mutual
- 23 support in the interest of patient safety.
- 24
- 25 (g) Encouraging development of inclusive training standards that enable individuals with
- 26 disabilities to enter the profession and have safe, successful careers.
- 27
- 28 (h) Eliminating stigma within the profession regarding illness and disability.
- 29
- 30 (i) Advocating for supportive services and accommodations to enable physicians who require
- 31 assistance to provide safe, effective care.
- 32
- 33 (j) Advocating for respectful and supportive, evidence-based peer review policies and
- 34 practices that will ensure patient safety and practice competency.
- 35

36 Modify HOD/CEJA policy

Fiscal Note: Less than \$500

## REFERENCES

1. Federation of State Medical Boards. Policy on Physician Impairment. FSMB.org. <https://www.fsmb.org/siteassets/advocacy/policies/physician-impairment.pdf> Published April, 2011. Accessed January 27, 2020.
2. Mull CC, et al. A call to restore your calling: self-care of the emergency physician in the face of life-changing stress-part 3 of 6: physician illness and impairment. *Pediatric Emergency Care*. 2019;35(8):585-588.
3. Pham CJ, Pronovost PJ, Skipper GE. Identification of physician impairment. *JAMA*. 2013;309(20):2101-2102.
4. Angelos P. How should colleagues respond to diminishing capacities of an aging surgeon? *AMA J Ethics*. 2016;18(10):986-992.
5. Moore IN. Screening older physicians for cognitive impairment: justifiable or discriminatory. *Health Matrix*. 2018;28:95-174.
6. Candilis PJ, Kim DT, et al. Physician impairment and rehabilitation: reintegration into medical practice while ensuring patient safety: a position paper from the American College of Physicians. *Annals Intern Med*. 2019;170(12):871-880.
7. Mossman D, Farrell H. Physician impairment: when should you report? *Current Psychiatry*. 2011;10(9):67-71.
8. Blauert CA. I use a wheelchair. and yes, i am your doctor. *New York Times*. <https://www.nytimes.com/2017/12/06/opinion/doctor-wheelchair-disability.html?auth=login-facebook>. Published December 6, 2017. Accessed January 30, 2020.
9. Iezzoni LI. Why increasing numbers of physicians with disability could improve care for patients with disability. *AMA J Ethics*. 2016;18(10):1041-1049.
10. Ouellette A. Patients to peers: barriers and opportunities for doctors with disabilities. *Nevada L.J.* 2013;13(3):645-667.
11. Waliany S. Health professionals with disabilities: motivating inclusiveness and representation. *AMA J Ethics*. 2016;18(10):971-974.
12. McKee M, et al. Medical schools' willingness to accommodate medical students with sensory and physical disabilities: ethical foundations of a functional challenge to "organic" technical standards. *AMA J Ethics*. 2016;18(10):993-1002.
13. Herzer KR. Moving from disability to possibility. *JAMA*. 2016;316(17):1767-1768.
14. Bohigian GM, Croughan JL, Sanders K. The impaired physician, Part II: Missouri State Physicians Health Program. *Mo Med*. 1994;91(6):275-277.
15. Federation of State Medical Boards. Report of the Special Committee on Reentry for the Ill Physician. FSMB.org. <https://www.fsmb.org/siteassets/advocacy/policies/reentry-for-the-ill-physician.pdf>. Published April, 2013. Accessed January 27, 2020.
16. Federation of State Medical Boards. Report on the Special Committee on Reentry to Practice. FSMB.org <https://www.fsmb.org/siteassets/advocacy/policies/special-committee-reentry-practice.pdf>. Published 2012. Accessed May 6, 2020.

SPEAKERS' REPORT 2 (June 2021)  
Report of the Election Task Force  
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and called on your Speakers to appoint a task force to recommend improvements to our AMA's election process. The task force presented a preliminary report at the 2019 Interim Meeting, and now presents its formal report. The election task force (ETF) diligently studied our current election process, carefully considered the comments received, and reviewed the survey conducted of the HOD at I-19. After extensive deliberation, 41 recommendations are proposed to improve our AMA election process.

The cost of running a successful campaign is generally the most prominent concern expressed. Expense is associated with several components of a typical AMA campaign. The ETF endeavored to reduce campaign costs with an emphasis on eliminating expenses that the HOD found not to be significant factors in the evaluation of candidates or in determining voting decisions. Along these lines the recommendations include elimination of campaign memorabilia, stickers, buttons, and pins, printed brochures, and direct mailing to members of the House while enhancing electronic communication and sponsoring a candidate website. In addition, an AMA reception is proposed to lessen the reliance on independent campaign receptions.

Candidate interviews were identified as the most important decision-making element in the AMA campaigns, yet concerns about equality were expressed. Accordingly, recommendations are offered to enhance and equalize opportunities for interviews.

Concern was raised that there is too much emphasis placed on campaigning and that the election process interrupts and distracts from more important policy discussion. The ETF proposes solutions to streamline our voting processes utilizing new technologies and a specific Election Session to answer this concern. One of the major sources of distraction has been when a current council or board member with an unexpired term creates an unscheduled newly opened position ("pop-up"). Modifying our announcement and nominations process combined with sequential electronic voting in effect eliminates these distractions. Several recommendations are offered to accomplish this.

Careful consideration was given to appointing council positions to eliminate many election issues. Appointment also allows for consideration of diversity and expertise needs. The ETF recommends appointment for a single council while other currently elected councils should continue to be elected.

The ETF believes our recommendations including reaffirming and enhancing our Guiding Principles for Election will provide candidates greater opportunity independent of delegations and caucuses, improve transparency, maintain an informed electorate, and improve fairness in the process.

The recommendations presented represent the consensus of the ETF, and we are confident that they will lead to improvement. However, this can only ultimately become clear once implemented, thus the final recommendation is for a review to be conducted after an interval of 2 years.



## REPORT OF THE SPEAKERS

Speakers' Report 2-JUN-21

Subject: Report of the Election Task Force

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and  
2 called on your Speakers to appoint a task force to recommend improvements to our AMA's  
3 election process. (See Appendix A for actual policy text.) Eleven people, primarily delegates, were  
4 appointed to the election task force (ETF) to serve alongside your Speakers, as we are charged with  
5 overall responsibility for AMA elections (G-610.020, Appendix B). The appointees are listed in  
6 Appendix A, and the task force's preliminary [report](#) was presented at I-19 as called for by the  
7 policy. Written comments have been solicited and several hours of debate were heard at an Open  
8 Forum held at I-19. Over the past two years the Speakers and the ETF have spent well over a  
9 hundred hours reviewing our current election processes, discussing concerns and deliberating  
10 possible solutions.

11  
12 The task force defined the following goals specific to our stakeholders:

13 For candidates: Remove obstacles that discourage qualified individuals from seeking elected  
14 positions and improve equity and transparency in the campaign.

15 For delegates: Provide ample opportunity to gain knowledge about each candidate (informed  
16 electorate) without undue distraction from policy development.

17 For our AMA and our members: Ensure the best possible governance with election of the most  
18 qualified candidates to lead our Association.

19  
20 Election-related concerns that underlay the call to review and improve election rules fall into four  
21 categories:

- 22 • *Cost, with the consensus being that campaigns are too expensive, which may dissuade some*  
23 *potential candidates, particularly those from smaller societies.*
- 24 • *Fairness, with concerns expressed about equality of opportunity for candidates from different*  
25 *delegations given the influence of sponsoring organizations.*
- 26 • *Distractions, with elections and the associated activities detracting from the development of*  
27 *AMA policy, which is the House of Delegates' primary purpose under the AMA constitution;*  
28 *this includes time required during House business sessions for speeches and voting, as well as*  
29 *various campaign activities.*
- 30 • *Technology, with hope expressed for a move towards electronic communications and more*  
31 *efficient mechanisms for voting.*

32  
33 These concerns are reflected in the resolutions submitted at the 2019 Annual Meeting, which are  
34 reproduced in Appendix C, in comments provided to the task force, and in survey responses  
35 provided by members of the House at I-19, which are presented in Appendix D; and are further  
36 discussed throughout this document (*set off by italics*). Many of our findings and recommendations  
37 relate to more than one of these concerns.

Current election rules are found in both AMA bylaws and policy (see Appendix B) but are also dependent on some Speaker rulings and discretion (eg, the cap on expenditures for giveaways). In proposing changes to our election processes, the task force has sought to ensure that the best candidates can be selected in free and fair elections while reducing obstacles, or perceived obstacles, that dissuade qualified members from seeking elective office. At the same time the task force has sought not to detract from the ability to ensure an informed electorate.

While this report proposes several changes to current rules, to be effective upon adjournment of this 2021 Special Meeting, worth repeating is a comment from the report of this task force dated November 2019:

[A]ddressing our AMA's election rules should be an evolutionary process, with the task force's recommendations only a step along a path that is sensitive to changes in technology, the needs of the profession, the diversity of AMA membership and the makeup of the House of Delegates.

Some of the reforms proposed should thus be considered initial steps, with additional changes somewhat dependent on the success—or failure—of the recommendations herein. Members of the task force have considerable experience either as candidates or as members of others' campaign teams, so the recommendations constitute the group's best current, collective judgement. Some of the recommendations flow from comments heard at the open forum and responses to the survey administered at I-19, which proved persuasive in many cases. In addition, several changes that were made of necessity to accommodate the virtual election process for the Special Meetings in June 2020 and 2021 served as models for proposed reforms. Every recommendation, however, derives from a consensus decision within the task force.

#### *Campaign Expense*

*The cost of running a successful campaign is generally the most prominent among concerns expressed. Whether costs are a real or a perceived problem is unclear insofar as a review of historical evidence shows that large expenditures do not necessarily lead to election. However, the concern does appear to discourage some otherwise qualified candidates from seeking office. Many societies that sponsor candidates are encountering tightened budgets, and concern has been expressed about the wisdom of expending members' dues money on AMA campaigns. Expense is associated with several components of a typical AMA campaign. Some of these are discussed below along with recommendations. The ETF endeavored to reduce campaign costs with an emphasis on eliminating expenses that the survey of the HOD found not to be significant factors in the evaluation of candidates or in determining voting decisions.*

#### CAMPAIGN MEMORABILIA

One of the most obvious expenses incurred by nearly every candidate is some sort of trinket or geegaw, generally imprinted with the candidate's name and distributed in the "not for official business" (NFOB) bag at the opening session of the Annual Meeting. While the overall expenditure is relatively small—a cap of \$3445 for such gifts to delegates and alternates at A19—it represents an easily foregone expense. One would surely hope that election decisions are not based on gifts, which over the last few years have included golf tees, pens, lip balm, cookies, candy, water bottles, calculators and small flashlights. In fact, the survey of the HOD found that only 6% of respondents consider these an important factor in determining their vote (see survey results in Appendix D).

Some concern was expressed about doing away with the giveaways, because some candidates make a contribution to the AMA Foundation in lieu of a giveaway. Doing away with giveaways

1 does not, however, preclude contributions to the Foundation. Anyone and everyone is not only  
2 invited but encouraged to donate to the Foundation. Moreover, over the last several years, few  
3 candidates have donated to the Foundation in lieu of providing a gift in the NFOB bag. Maintaining  
4 giveaways to facilitate relatively rare "in-lieu-of" donations to the Foundation seems a bit  
5 disingenuous, particularly as donors can just as easily proclaim their support of the Foundation in  
6 more efficient ways.

7  
8 Your task force struggled somewhat with gifts that are provided by certain delegations in the  
9 NFOB bag seemingly every year whether or not they have a candidate. These would fall under the  
10 rule for giveaways from candidates in any year in which that delegation had a candidate and a  
11 candidate's name was associated with the item, and while not directly linked to a candidate in other  
12 years, could be interpreted as an inducement for future candidates from that delegation. In addition,  
13 the task force felt any exceptions to the rule would complicate enforcement and potentially lead to  
14 a slippery slope with other delegations deciding to supply giveaways every year to remain  
15 competitive. In addition, observations at the last two in-person meetings found a majority of the  
16 material in the NFOB bag was left on the tables or otherwise discarded. Given the move towards  
17 electronic communication and an overall desire to reduce waste, your ETF is recommending the  
18 elimination of all campaign materials distributed in the NFOB bag. Although beyond our purview,  
19 we believe the other materials that are included in the NFOB bag should also be discontinued or  
20 distributed in other more meaningful ways. Ultimately, we believe the entire NFOB bag should be  
21 eliminated.

22  
23 The ETF discussed whether delegations should be allowed to provide token gifts at a reception. For  
24 some delegations the gift or raffle item has become a tradition at their reception. The ETF decided  
25 not to recommend prohibiting such giveaways as long as they do not include a candidate's name or  
26 likeness. We recommend monitoring this to see if delegations attempt to indirectly link these gifts  
27 to campaigns or use them as an inducement for a vote, in which case they could be prohibited in  
28 the future.

## 29 30 STICKERS, BUTTONS, and PINS

31  
32 Another area which may seem trivial but adds to the overall cost of a campaign with little to no  
33 perceived impact on the election outcome is stickers, buttons, ribbons and pins. While they don't  
34 cost much, every dollar counts. In addition to the expense, these items appear to have negative  
35 appeal to a number of delegates. Your ETF heard many negative comments about "forced  
36 stickering" particularly in receiving lines at receptions. Individuals said they felt pressured to  
37 accept and wear stickers, even for candidates they did not support. Others responded that they wear  
38 every candidate's stickers, which diminishes the value of all the stickers and clutters their badge.  
39 The necessary increased security surrounding our recent meetings, including measures added to our  
40 badges, pose an additional argument against stickers, and placing stickers other than on badges  
41 may conflict with our enhanced behavior policies. Buttons and pins share similar negatives and  
42 create holes in clothing. Finally, all of these, particularly when multiple are worn, project a less  
43 than professional image to our meeting and elections. The ETF recommends that campaign  
44 stickers, pins and buttons be disallowed.

45  
46 Distinctly separate from the above are pins and ribbons worn to designate support of AMPAC and  
47 our AMA Foundation. Pins for specialties, delegations, regions and even certain causes that do not  
48 include any candidate identifier should be allowed. These should be small, not worn on the badge  
49 and distributed only to members of the designated group. To prevent a "slippery slope" or  
50 problems with enforcement, general distribution of any pin, button or sticker would be disallowed  
51 no matter how worthy the cause.

## CAMPAIGN RECEPTIONS

A reception is probably the largest single expenditure for most campaigns, with the cost ranging from several thousand to 20 or even 30 thousand dollars, even with our current election rules, adopted by this House several years ago, which disallow alcohol unless available only on a cash bar basis. Such prices make the cost of a reception an impediment or unbearable by some potential candidates. Even candidates from larger delegations have expressed concern about the expense, and some candidates have used personal funds to finance part or all of the expense.

Experience over the last few years also suggests that the impact of a reception on campaign success is, at best, questionable, as candidates who have been featured at a large reception have not been successful in their campaigns, while some with a small or no reception have been successful. Responses to the survey administered at the 2019 Interim Meeting provide support for this position. Fully one-third of the House indicated that receptions are not a factor in determining their votes, and another quarter indicated that receptions were a minimal factor in voting; together those figures constitute three-fifths of the House. Fewer than one in five members of the House indicated that receptions are an important or very important factor in their voting decisions. Yet, your task force heard comments that some delegations wish to continue their receptions.

While a majority of delegates consider receptions of little importance in their election vote, your task force heard multiple comments supporting the existence of receptions for the opportunities they provide for informal social interaction, meeting new individuals and even policy discussion. It is important to note that receptions in their current form are typically open to all, and in fact, candidates seem to be comfortable attending and campaigning at receptions even when sponsored by a competing campaign. Some felt that receptions allowed delegates to interact with candidates (not just the “featured candidate”) in an informal and often more personal way.

Current rules allow each candidate to be “featured” (defined in our election rules as being present in a receiving line, appearing by name or in a picture on a poster or notice in or outside of the party venue, ...) at only one reception. Delegations or coalitions may finance only a single large reception regardless of the number of candidates from that society or coalition. As noted above, alcohol may be served at these receptions only on a cash bar basis (G-610.020).

Your ETF agrees that there is value to candidates and delegates interacting in social settings outside the rigors of an interview and other formal campaign activities, but we also recognize that the expense of a reception may be a deterrent or cause financial strain for many potential candidates. We hesitate to tell delegations that they may not host a reception but want to create a similar opportunity for other candidates without the resources to host a reception.

In lieu of the multiple, competing receptions sponsored by individual campaigns, we are recommending that our AMA investigate the feasibility of sponsoring a welcome reception open to all candidates and all meeting attendees. Such a reception could allow any candidate the opportunity to be “featured” at the AMA reception. Featured candidates could be allowed to set up in a space within the reception to visit with anyone who chooses to stop by or could choose to circulate among guests. Such an arrangement would do away with the receiving lines, about which the task force heard negative commentary, and the “forced stickering” that seems to occur whenever one enters the current receptions (see above for further discussion of campaign stickers). It would facilitate informal interaction between candidates and members of the House. Two-thirds of those responding to the survey of the House (Appendix D) indicated that they probably or almost certainly would attend such an event. Nothing in this recommendation would prevent other candidates who elect not to use this reception as their single allowed reception from attending.

Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain.

#### DINNERS, SUITES AND SUCH

Significant money is spent on informal dinners and entertainment in suites. These are often held at AMA events before active campaigning is allowed. These gatherings are inherently difficult to monitor and to enforce potential rules regarding them. Interestingly, these gatherings actually scored better in the HOD survey than large receptions (see survey results in Appendix D). Some say these are a great way to meet fellow delegates while others point to this as an extravagance that many candidates cannot afford.

The task force recognizes that meeting attendees enjoy these informal social gatherings but has sought to reduce the actual or perceived expense of campaigning. The major concern expressed is indeed the cost. To address this the ETF recommends that any group dinners, if attended by an announced candidate (see Announcement and Nomination below) in a currently contested election, must be "Dutch treat," each participant paying their share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Recognizing that candidates should be allowed to dine with a small group of friends or share the tab at the bar without fear of a campaign violation, we propose that gatherings of 4 or fewer delegates or alternate delegates should be exempt.

Given the complexity of enforcement and the relatively less opportunity for excess, the task force does not make any recommendation for limiting interactions in delegation suites at this time. All are reminded that active campaigning prior to the April date, whether in a suite or elsewhere, is specifically prohibited by other rules.

#### CAMPAIGN LITERATURE

Brochures, letters, flyers and other campaign literature are often mailed to delegates before the Annual Meeting and distributed in the not for official business (NFOB) bag at the opening session. According to the survey of the House (Appendix D), these materials carry little impact on the delegate's vote, regardless of how delivered, yet require significant expenditure to develop, print and distribute. Just six percent of respondents in the House find mailed literature important or very important. Slightly more than half declared that campaign literature was not a factor in determining their vote, and more than a quarter reported it to be of minimal importance. The task force has even heard that a surplus of such material can have a negative impact on a candidate's chances. Campaign material emailed before the meeting fared only slightly better: almost seven percent found it important or very important and three-quarters reported it to be of no or minimal import. Literature distributed in the NFOB bag performed no better than items distributed before the meeting. In fact, a casual survey of the House after the opening session would find most of the campaign literature still in the bags, on the floor, or in receptacles near the exits.

These materials as currently distributed constitute an unnecessary expense and waste of resources particularly because they go unread by the vast majority of delegates. Furthermore, we recognize that some candidates have resources for developing such materials that are not available to other candidates or potential candidates. However, your task force believes an informed electorate needs

1 to have available information about candidates' background, experience and qualifications for the  
2 position they seek. We encourage elimination of all printed campaign materials while  
3 recommending an alternate electronic means of providing this information on a more equal  
4 platform. It seems few if any candidates "want" to send these materials, but most feel "required" to  
5 send because other candidates do. Because mailed materials carry the greatest expense we propose  
6 prohibiting these and would end the current process of the HOD office supplying a list of postal  
7 addresses to candidates. The election manual has not been printed since 2015 with no apparent  
8 negative effects, and in fact, when the House adopted the policy to move to an exclusively online  
9 manual, not a single concern was raised, nor have concerns been raised since.

10  
11 In lieu of printed material, we propose maintaining the online election manual and providing each  
12 candidate the opportunity to post materials on the AMA website, within an expanded elections-  
13 related set of pages (see discussion below), and the election manual would link to these pages as it  
14 does to conflict of interest statements.

## 15 16 ELECTRONIC COMMUNICATION

17  
18 The AMA rules of contact and privacy policy have been interpreted to not allow the HOD to  
19 provide delegate/alternate delegate email addresses to candidates. The ETF has heard that some  
20 campaigns have "harvested" email addresses from the pictorial directory and others have not. At  
21 best this creates inequality and could even be seen as contrary to the spirit of AMA policy against  
22 sharing email addresses. It is necessary that your Speakers and the HOD Office be able to contact  
23 members of the House with confidence that the messages will not be regarded as spam; thus your  
24 Speakers strive to limit our communications to essential material. At no time was this more clear  
25 than leading up to the Special Meetings in the last year. Options of requiring "opting in" or "opting  
26 out" so email addresses can be shared with campaigns, as some have suggested, could threaten  
27 essential HOD communication. AMA corporate policies would likely be interpreted as not  
28 allowing "opting in" as a default and even candidates have expressed that they believe few would  
29 elect to "opt in" if required to make this choice.

30  
31 For the June 2020 Special Meeting, the Speakers, upon request from the majority of candidates,  
32 provided the opportunity for candidates to submit material to the HOD office which was then sent  
33 electronically by the HOD in a single communication to all delegates and alternates. While this was  
34 optional, every candidate took advantage of this opportunity. Parameters were established  
35 regarding content, but there was considerable variability in the materials submitted, ranging from  
36 resume style materials and photos to simple prose messages or endorsements. Favorable feedback  
37 was received and the Speakers have continued this process for June 2021. The ETF recommends  
38 continuation of this process even after return to in-person meetings.

39  
40 A goal of the ETF was to create an equal opportunity for all candidates to share information  
41 regarding their candidacy while also reducing the amount of unwelcomed material that delegates  
42 receive. At the same time, the task force did not want to create communication rules that would be  
43 difficult to track and enforce. While this recommendation does not prohibit candidates from  
44 sending their own additional electronic campaign messages, campaigns are reminded that current  
45 campaign rules require that any such communication must include an "unsubscribe option." Many  
46 delegates expressed that electronic communications from individual candidates are unwanted and  
47 may even negatively impact their view of the candidate. Given the electronic communication we  
48 propose to be sent by the HOD office on behalf of all candidates it should be anticipated that  
49 additional electronic communications from individual candidates would not be well received. With  
50 the enhanced opportunity to communicate, we would anticipate less tolerance of mass

communications by candidates and more reporting of the failure to include an unsubscribe option for all such campaign related emails.

#### WEBSITES AND SOCIAL MEDIA

As mentioned above, the ETF recommends providing each candidate the opportunity to post materials on the AMA website, within an expanded elections-related set of pages. Although the parameters need to be established, the task force envisions a web page template supported by the AMA that could be filled in by candidates without resorting to web design experts. For example, one page might incorporate a biographical resume style listing, another page might incorporate photos of the candidate's selection, and a third page might allow the candidate to post position statements or other information about themselves or that they consider relevant to their campaign. Some design elements might be left up to the candidate (eg, colors and fonts) even while the overall structure of the page(s) is consistent across candidates.

This proposal is supported by the survey of the House at I-19, in which fewer than one in seven delegates indicated that they "probably" or "almost for sure" look at a candidate's website, whereas over half said they would probably or "almost for sure" look at an AMA candidate site. In addition, the fact that all candidate sites would be listed together and linked to the election manual would facilitate delegates review of the material (they would not have to search for individual websites). Candidates would submit their material and all pages would go live simultaneously once campaigning is officially allowed.

At this time, the ETF does not recommend prohibiting candidates from having personal, professional or even campaign-related websites, but the election manual would not link to these independent candidate pages. Similarly, we do not recommend attempting to prohibit or control social media. These forms of communication are embraced by many and importantly individuals must elect to go to the sites or join to receive messages. Since these are not "pushed" to anyone, it should eliminate the concerns of those that feel overwhelmed with electronic information while still providing a resource for delegates that want more information about the candidates.

#### *Fairness*

*Concern was expressed about inequality of opportunity and the undue influence of caucuses and sponsoring organizations. The ETF hopes that by reducing many of the campaign expenses with the recommendations above, the obstacle of cost will be lowered for all candidates, including those from smaller delegations or with less deep pockets. With all candidates able to participate in the AMA reception, post on the AMA website candidates' pages, and participate in electronic communication originating from the HOD office, opportunities should be less dependent on a candidate's caucus or sponsoring organization. The survey identified interviews as having the greatest influence on the voting decision and our recommendations below should enhance fairness and transparency for this process.*

#### INTERVIEWS

In the survey of our HOD at I-19, candidate interviews were far and away the most important decision-making element in our AMA's election processes, considered an important or very important factor by more than three quarters of those responding (Appendix D). The task force fully agrees with the importance of interviewing.

At the same time, the number of interviews and the time required for them has been likened to a gauntlet for the candidates, and it is no less onerous for those conducting the interviews. For

1 example, at A-19, interviews for contested slots would require no less than 13 interviews if every  
2 candidate was to be interviewed. Ten-minute interviews thus require over two hours, not including  
3 any "travel time" between interviews. Added to the actual interviewing time is the time required to  
4 arrange and manage these interviews, which is necessary for both the candidates and the  
5 interviewers. Yet, virtually every person who spoke on the issue at the open forum, including  
6 successful and unsuccessful candidates, expressed the view that the interview process was a  
7 valuable experience. A clear majority expressed that interviews were time well spent to meet and  
8 become informed about the candidates.

9  
10 Some delegations expressed that the stream of candidates interrupts their policy deliberations.  
11 Other delegations responded that they use interview committees, made up of delegates with special  
12 interest in a particular council's activities, which often meet simultaneously with candidates for  
13 different races, thus lessening the time required for interviews. The task force believes this may be  
14 an acceptable option for some delegations.

15  
16 Consideration was given to grouping interviews together. Over the past several years the HOD  
17 office has coordinated grouping section interviews together but has received negative reaction from  
18 the groups preferring to have their own interviews. At the open forum and in communications since  
19 there has been broad support from delegations to be allowed to continue their specific interviews.  
20 While your task force believes grouping of interviews to reduce the number of interviews is  
21 desirable, we believe such grouping is best done voluntarily by delegations that find they share  
22 similar interests.

23  
24 Others suggested that interviews be held in a format in which candidates assemble at an appointed  
25 hour in front of those who are interested and questions are asked by a moderator similar to the  
26 debate held when the president-elect race is contested. Concerns were raised regarding the stress  
27 that would be associated with such a high stakes interview, particularly for council candidates who  
28 would not typically face such a situation during council service. Others commented that these  
29 interviews often result in candidates repeating or even learning from the responses of those  
30 answering before them. The Specialty and Service Society holds such an interview panel, yet many  
31 specialty delegations continue separate interviews. Several large delegations and even small  
32 delegations confirmed that they would continue their interviews even if such a group interview  
33 process was instituted, seemingly adding another round of interviews during an already packed  
34 meeting rather than replacing or eliminating interviews.

35  
36 Of necessity for the June 2020 Special Meeting and now again for J-21, virtual interviews have  
37 been conducted by both the Speakers and individual caucuses and delegations. Given the overall  
38 positive feedback received, the task force recommends continuing the option for virtual interviews,  
39 including recorded interviews by the Speakers, in advance of the meeting even after we return to  
40 in-person meetings. In addition, the Speakers would continue to conduct interviews with all  
41 candidates to be posted on the AMA website.

42  
43 Virtual interviews would be allowed during a defined period prior to the meeting in lieu of in-  
44 person interviews. Caucuses could choose either method, but not both for a given race. For  
45 example, a caucus may choose to conduct virtual interviews for all council races but choose to  
46 conduct live interviews for all officer races. These interviews would be facilitated by the HOD  
47 Office similarly to how they have been handled for the June 2020 and 2021 campaigns. Recording  
48 of virtual interviews must be disclosed to candidates prior to recording and only with their consent,  
49 and the recordings may only be shared with members of the interviewing caucus/group.



1 It has been reported that some candidates have been unable to schedule interviews with some  
 2 groups, and some groups interview some but not all candidates for a given office. In addition, some  
 3 candidates have been unaware of the opportunity to interview with some groups or did not know  
 4 how to arrange such an interview. Democratic principles should favor interviewing all announced  
 5 candidates for an office. To create equal opportunity for all candidates, we recommend a rule that  
 6 requires groups electing to interview candidates for a given office to provide an equal opportunity  
 7 for all currently announced candidates for that office to be interviewed using the same format and  
 8 platform. An exception would allow a group to meet with a candidate who is from their own  
 9 delegation without interviewing other candidates. This rule would apply to both virtual and in  
 10 person interviews.

#### 11 *Distractions and Technology*

12 *Concern raised was that there is too much emphasis placed on campaigning and that the election*  
 13 *process interrupts and distracts from more important policy discussion. Others expressed that*  
 14 *election of leadership is an essential function of our House and a core responsibility of delegates.*  
 15 *Your ETF believes both viewpoints are valid and has sought to design a process that is less*  
 16 *disruptive to our policy deliberation, consumes less time, and yet allows for secure voting. This can*  
 17 *be accomplished by streamlining our processes and utilizing new technologies.*

#### 19 VOTING PROCESS AND ELECTIONS SESSION

20  
 21  
 22 Our current voting process at in-person meetings crafted by bylaws, rules, and tradition developed  
 23 20 plus years ago involves casting ballots in a separate room in “voting booths” on Tuesday  
 24 morning during a 75-minute voting window. Results for each race are announced in the House  
 25 once they become available, typically 30-40 minutes after the House has come to order,  
 26 interrupting the discussion of reference committee reports. Oftentimes, runoff voting is required  
 27 and accomplished using paper ballots which are printed, distributed, collected and counted (by  
 28 hand) by the election tellers, again disrupting the policy discussion. If new openings are created,  
 29 new nominations, speeches, voting and possibly further runoffs all interrupt House debate. Twice  
 30 in the last several years elections have extended to Wednesday morning. Voting delegates must be  
 31 seated at these somewhat random moments to receive a ballot, resulting in reshuffling of delegates  
 32 and alternate delegates, further disrupting the deliberations. All of this when combined with  
 33 appreciation and concession speeches, consumes considerable time and detracts from policy  
 34 discussion. While initial voting is secure in a private booth, runoff paper ballots are distributed in  
 35 the House to credentialed delegates only, but there is little actual security in this regard as ballots  
 36 are “passed down the row.”

37  
 38 The original resolutions adopted by the HOD specifically called for consideration of electronic  
 39 voting. In 2020, in the virtual format, all the voting was done electronically by necessity. Electronic  
 40 voting was secure and effective in the virtual situation and should be acceptable in person. We are  
 41 confident that voting can be done with the electronic voting devices—colloquially referred to as  
 42 “clickers”—that are used in business sessions of the House. The devices are easy to use, and their  
 43 security and privacy features are at least as great as current methods. Briefly described, delegates  
 44 (not alternate delegates) can be issued a security card that must be inserted into the device in order  
 45 to vote in elections. While all devices can be used to vote on policy matters without the card, the  
 46 security card is required to cast a vote in an election. Each vote should take under a minute, results  
 47 are almost instantaneous and the devices can be reset for a runoff election within a minute or two.  
 48 Given the virtual nature of the June 21 HOD meeting, election voting will again be electronic.  
 49 Accordingly, the ETF recommends that electronic voting should be continued when we return to  
 50 in-person elections at the 2022 Annual Meeting. We believe this change will simplify voting, allow  
 51 results of each race including runoffs to be known before ballots are cast for the next position and

1 facilitate a new method of handling positions that were unscheduled but created by a prior election  
2 result, henceforth “newly opened positions” (see Newly Opened Positions below).  
3

4 To further reduce the interruption of policy discussion, our Speakers have scheduled a specific  
5 “Election Session” on the agenda for the June 21 HOD meeting. All election activity (except for  
6 those unopposed candidates elected by acclamation at the time of nominations) including voting,  
7 runoffs and speeches will occur at a scheduled time on Tuesday morning (see discussion on “the  
8 day of elections”) separate from policymaking sessions. The House deliberation of reference  
9 committee reports will resume at a “time certain” to be specified. Delegates only will be voting at  
10 this time, but alternates and guests are welcome to observe. The ETF recommends continuing this  
11 scheduling once in-person meetings resume.  
12

13 Additionally, while the task force understands the tradition of thank you speeches by both the  
14 victors and unsuccessful candidates, the task force nevertheless prefers that all such speeches be  
15 discontinued. No one doubts the sincerity of the thank you delivered by those speaking, but those  
16 words of appreciation could better be delivered privately. Moreover, sparing losing candidates the  
17 discomfort, often palpable throughout the House, of appearing at a microphone shortly after  
18 hearing negative results should be considered a kindness, not a slight, and allows them a graceful  
19 exit. These “points of personal privilege” were not heard in June 2020 and will not occur in June  
20 2021. Candidates were invited to share written comments which were subsequently sent to the  
21 House. The Speakers have heard no complaints regarding this decision. Our intention is not to  
22 create a rule disallowing these speeches (since no rule allowing them exists), but rather to set the  
23 stage for the Speakers to use their discretion based upon the volume of business at hand and the  
24 number of candidates. We encourage the Speakers to continue to collect personal points from  
25 candidates and share them electronically with the House after the meeting, eliminating the need for  
26 the speeches during the meeting itself. If such speeches are allowed in the future, we strongly  
27 suggest that they be limited to 60 seconds.  
28

29 With these proposed changes, the task force believes voting will be secure, the time consumed for  
30 elections will be greatly reduced, and there will be no interruptions of policy discussion.  
31

## 32 ANNOUNCEMENTS AND NOMINATIONS 33

34 The ETF considered various announcement/nomination scenarios with the intent of clarifying this  
35 process, increasing vetting of all candidates, ameliorating the negative aspects of “pop-ups” (see  
36 Newly Opened Positions below) and maintaining the time limit on active campaigning to the  
37 period of April through June.  
38

39 Currently candidates for all elected positions may announce their candidacy with a virtual card  
40 projected at the conclusion of the Annual and/or Interim Meetings and then posted on the AMA  
41 candidate website. In addition, current rules allow candidates that do not submit an announcement  
42 card at these times to send an announcement to delegates even before the “active campaign” has  
43 begun. As a result candidates may in effect announce their candidacy directly to delegates at any  
44 time, making it difficult to stay abreast of all current candidates for a particular position.  
45

46 The ETF believes that this loophole should be closed and that such announcements, just like any  
47 other campaign communication, sent to delegates before active campaigning is allowed would be a  
48 violation of campaign rules. In addition, we propose additional “official” announcement dates be  
49 established at which time additional announcements cards would be added to the AMA website and  
50 communication would be sent to the HOD. Under our proposal any candidate could still

1 independently announce their candidacy after active campaigning is allowed, but no formal  
2 announcement from the HOD office will take place other than at the specified times.

3  
4 We propose that the HOD office review all known candidates following the Annual and Interim  
5 Meetings and at other specified announcement times to identify unscheduled seats that may  
6 potentially be newly opened by election of any announced candidates and communicate this  
7 information to the House along with the names of all the candidates for each position. These  
8 "Official Candidate Notifications" would add transparency and alert delegations and members of  
9 the possibility of unscheduled positions that may become open if certain announced candidates are  
10 elected. Members interested in becoming candidates for open or potential newly opened positions  
11 would be required to send a virtual announcement card to the HOD Office and complete a conflict  
12 of interest (COI) form.

13  
14 The AMA Board of Trustees considers applications from council candidates at its April meeting  
15 and then announces the candidates shortly thereafter. Active campaigning is allowed after this  
16 announcement. Currently there is no official notification and oftentimes delegates are uncertain of  
17 the exact date of the BOT meeting and start of active campaigning. Therefore, at this time another  
18 "Official Candidate Notification" would be sent to the HOD. This would also signal the start of the  
19 active campaigning period. Subsequent "Official Announcement Dates" would be determined by  
20 the Speakers.

21  
22 Candidates who become aware of potential newly opened positions for any office or council could  
23 notify the HOD Office at any date of their intent to join the campaign and then would be included  
24 at the next official announcement and in all subsequent announcements. Presumably this would  
25 occur well before nominations occur at the Opening Session of the House. All previously  
26 announced candidates will continue to be included at each official announcement (i.e. those  
27 announced in June will again be presented in November, April, etc.) and all who had notified the  
28 HOD Office of their intent to be nominated and completed a COI would be included in any  
29 campaign activity that had not yet been finalized. This modified announcement process would not  
30 prohibit late entry into the campaign but provides advantages to early entries.

31  
32 As discussed below, our bylaws allow for nomination "from the floor" during the Opening Session  
33 of the HOD, so candidates could elect to be nominated who had not notified the HOD office of  
34 their intent and who had not been included in any official announcement. While it would still be  
35 possible for a new candidate to first announce at the time they are nominated from the floor at the  
36 Opening Session of the House, waiting until this moment when given the opportunity to announce  
37 their candidacy in advance, would seem to put that candidate at a significant disadvantage, thus  
38 encouraging candidates to announce early and be vetted. The earlier the announcement, the more  
39 the opportunity to participate in the campaign process, including interviews which the survey  
40 identified as the most important factor in the voting decision. This proposal would allow for  
41 posting of the COI at the time of announcement (likely well before election day) or at the latest at  
42 the Opening Session of the House, more than two days before the election in our current schedule.

43  
44 The task force carefully considered the bylaws that allow for nominations from the floor during the  
45 Opening Session. This bylaw is common among associations that hold open nominations and  
46 elections. Typically nominations are declared open and then closed by a motion. No doubt this  
47 option complicates the campaign process and potentially creates chaos at the last moment.  
48 However, nomination at the last possible minute allows for the rare case where a candidate is  
49 determined to be unavailable or unacceptable to fill a position, or a late nominated candidate for  
50 some reason is an overwhelming choice. While relatively rare, this has occurred, and candidates  
51 waiting until this last moment have been elected. The ETF believes this option should remain and

1 recommends the more formalized announcement process as a solution to at least the most common  
2 aspects of the problem of late announcements and unvetted candidates.

3  
4 During the ETF exploration of announcements and nominations we found inconsistencies in our  
5 rules surrounding the concept of announcements versus nominations. These two terms seem to be  
6 used interchangeably without a clear delineation between the two. For example, we could not find a  
7 basis for the Board nominating council candidates in conjunction with the April Board meeting.  
8 Bylaw 6.8.1 specifies that nominations for the elected councils are made by the Board or by a  
9 delegate from the floor. It does not specify when the Board actually places the names of their  
10 nominees into nomination. In fact, as discussed in the paragraphs above and below all nominations  
11 actually occur at the Opening Session of the House. Under the current process, candidates for  
12 council positions submit applications to the Board for consideration at their April meeting prior to  
13 an established March 15 deadline as discussed in Policy G-610.010, "Nominations," shown below  
14 [*emphasis added*]:

15  
16 Policy G-610.010, Nominations

17 Guidelines for nominations for AMA elected offices include the following: (1) every effort  
18 should be made to nominate two or more eligible members for each Council vacancy; (2) the  
19 Federation (in nominating or sponsoring candidates for leadership positions), the House of  
20 Delegates (in electing Council and Board members), and the Board, the Speakers, and the  
21 President (in appointing or nominating physicians for service on AMA Councils or in other  
22 leadership positions) to consider the need to enhance and promote diversity; (3) the date for  
23 submission of nominations to the Council on Legislation, Council on Constitution and Bylaws,  
24 Council on Medical Education, Council on Medical Service, Council on Science and Public  
25 Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial  
26 Affairs is made uniform to March 15th of each year; (4) the announcement of the Council  
27 nominations and the official ballot should list candidates in alphabetical order by name only;

28  
29 These "nominations" are then announced at the conclusion of the Board's April meeting at which  
30 time active campaigning may begin. Policy G-610.020 which reads in item 3 [*emphasis added*]:

31  
32 (3) Active campaigning for AMA elective office may not begin until the Board of Trustees,  
33 after its April meeting, announces the nominees for council seats. Active campaigning includes  
34 mass outreach activities directed to all or a significant portion of the members of the House of  
35 Delegates and communicated by or on behalf of the candidate. If in the judgment of the  
36 Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns  
37 may formally begin, the Speaker shall communicate the earlier date to all known candidates;

38  
39 It is our understanding that Policy G-610.020 (3) was written more to define the start of active  
40 campaigning rather than to specify the timing of the nomination process. Note that this only  
41 specifies the Board "announcing the nominees" for council candidates; they are actually nominated  
42 by the Board at the Opening of the House. However, council candidates under our current rules  
43 may "announce" their candidacy at any point, even after the March deadline, and then be  
44 nominated "from the floor" by a delegate without completing an application or being considered by  
45 the Board. Review of available history did not identify a single instance when the Board did not  
46 "nominate" a council candidate who submitted an application. In reality the Board review of these  
47 candidates, who must be AMA members, is largely perfunctory. Procedurally nominations are  
48 declared open by the presiding officer, nominations are announced by the presiding officer or  
49 Board chair or made from the floor by a delegate. Then a motion is accepted to close nominations  
50 (typically the presiding officer will accept nominations be closed "without objection" once no  
51 further nominations appear to be pending even without a formal motion and second). To eliminate

1 the confusion between nomination and submitting applications for review by the Board at their  
2 April meeting while maintaining the uniform March 15 deadline, the ETF recommends Policy  
3 G-610.010, "Nominations," paragraph 3 be amended.

4  
5 Guidelines for nominations for AMA elected offices include the following: (1) every effort  
6 should be made to nominate two or more eligible members for each Council vacancy; (2) the  
7 Federation (in nominating or sponsoring candidates for leadership positions), the House of  
8 Delegates (in electing Council and Board members), and the Board, the Speakers, and the  
9 President (in appointing or nominating physicians for service on AMA Councils or in other  
10 leadership positions) to consider the need to enhance and promote diversity; (3) the date for  
11 submission of ~~nominations to applications for consideration by the Board of Trustees at its~~  
12 April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on  
13 Medical Education, Council on Medical Service, Council on Science and Public Health,  
14 Council on Long Range Planning and Development, and Council on Ethical and Judicial  
15 Affairs is made uniform to March 15th of each year; (4) the announcement of the Council  
16 nominations and the official ballot should list candidates in alphabetical order by name only;

17  
18 In addition, Policy G-610.020 (3) be amended by deleting the word "nominees" and inserting the  
19 word "candidates" to clarify that the Board is announcing the candidates and not actually  
20 nominating them.

21  
22 (3) Active campaigning for AMA elective office may not begin until the Board of Trustees,  
23 after its April meeting, announces the ~~nominees~~ candidates for council seats. Active  
24 campaigning includes mass outreach activities directed to all or a significant portion of the  
25 members of the House of Delegates and communicated by or on behalf of the candidate. If in  
26 the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by  
27 which campaigns may formally begin, the Speaker shall communicate the earlier date to all  
28 known candidates;

29  
30 The ETF believes these proposed changes to our announcement process will clarify the process  
31 while maintaining the current nominations that occur at the Opening Session of the House. These  
32 changes provide transparency for delegates to know the candidates for all positions and have an  
33 opportunity to vet those candidates. It also allows potential candidates to learn of the opportunities  
34 to run for an unscheduled position that may become newly open as a result of another pending  
35 election.

#### 36 37 NEWLY OPENED POSITIONS

38  
39 Significant concern was raised regarding how to handle elections to fill previously unscheduled  
40 vacancies that are created as a result of prior elections. This most often occurs when a council  
41 member with an unexpired term is elected to an officer position but may also occur when a current  
42 Board member with a continuing term becomes president-elect. Current bylaws prescribe that the  
43 newly opened position is filled in a separate election with nominations to be held after completion  
44 of election for previously known open positions. Over the past several years multiple previously  
45 unannounced candidates are then nominated, all candidates give a speech before the House and  
46 then voting ensues. In the past these have been called "pop-ups."

47  
48 Three general concerns have been expressed regarding "pop-up:" first, these individuals are being  
49 elected without the usual vetting; second, the process of new nominations and speeches before the  
50 HOD delays and distracts from policy discussion; and third, the possibility of opening a seat has  
51 become a campaign strategy. In addition, our rules require a conflict of interest disclosure to be

submitted before the election and presumably there should be ample opportunity for delegates to review the COI before voting. The ETF considered a number of potential solutions, including requiring candidates seeking another office to resign their current position, leaving the seat of a successful candidate vacant until the next meeting, delaying voting on these positions until the next day, or forcing potential candidates to declare in advance (an analysis of each of these options is included in Appendix E).

These options were discussed at the open forum held at the 2019 Interim Meeting and were also a subject of the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. After further exploration, the ETF discovered that simply embracing newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation eliminates most of the problems associated with "pop-ups" without necessitating the more radical changes associated with the options presented at I-19.

The problems associated with newly opened positions are the result of the limitations of our current voting process. The change in our election process to electronic voting as detailed above (see Election Process) technically eliminates "pop-ups." Pop-ups occur only when a new position opens "that did not exist at the time of the prior ballot" (Bylaws 3.4.2.2 and 6.8.1.5). With sequential electronic voting all open positions, including those created by a preceding vote for an officer position, will "exist" at the time of the initial ballot. During the election session, proposed above, the vote for the Board of Trustees will be held (including any runoffs) with the results known, before the first ballot and voting for the councils will occur. With this process there has been no "prior ballot" for any of the councils. Similarly, the vote for president-elect will be concluded before the voting for the Board begins. For example, hypothetically a current member of the Council on Medical Service (CMS) with an unexpired term is elected to the Board; the first vote for CMS will occur after the result of the Board election is known. Therefore, the first ballot for CMS will include candidates for all open seats including the newly opened position. With this process there is no "newly opened seat that did not exist at the time of the first ballot," thus no "pop-up," no new nominations, and no speeches before the House. Based upon the change to electronic voting for each position in a sequential fashion, Bylaws 3.4.2.2 and 6.8.1.5 are no longer relevant, and we recommend they be rescinded to eliminate future confusion.

While this technically eliminates "pop-ups," this does not completely solve the problem. Nominations are accepted on Saturday afternoon (in our usual meeting schedule) and elections are held on Tuesday. Therefore, candidates who are considering nomination do not know whether a newly opened position will be created before the close of nominations. To solve this problem, the ETF is suggesting a modified announcement and nominations process that entails informing delegates at specific times in advance of the meeting of the current candidates for each position and the seats that could potentially be newly opened as a result of pending elections (see Announcements and Nominations). The proposed process as detailed above includes a series of announcement deadlines with notification sent to delegates with subsequent opportunity for new candidates to announce their intention to run for these potential newly opened positions. This proposed announcement process will encourage candidates to announce in advance for potential newly opened positions and require candidates that hope to be elected to one of these positions to be nominated during the Opening Session of the House. Changes suggested below will allow candidates the opportunity to withdraw their nomination in the event the potential seat does not open. However, once nominations are closed, no further nominations will be accepted. This proposal, while requiring candidates to be nominated for a position that may not ultimately open, will allow vetting of candidates that announce their intention to be nominated.

1 Currently when an unopposed candidate with an unexpired term is elected by acclamation,  
2 nominations for the newly opened council or Board seat are accepted at the time of initial  
3 nominations along with nominations for any previously known open seats. In fact, this is the model  
4 we have used above in our proposal to handle potential newly opened positions.

5  
6 If there are no open positions scheduled for election in a given year for a particular council or the  
7 Board, but there is the potential for a newly opened position (one or more current candidates for a  
8 higher office hold an unexpired term on a council or the Board) candidates will be solicited as  
9 detailed above for the potential newly opened position. These announced candidates for the  
10 potential newly opened position will proceed with all campaign activities available to them from  
11 the time of their announcement forward. If the potential newly opened position does not open (ie.,  
12 the individual with the unexpired term is not elected to the office they sought), no election will be  
13 held. In this event these candidates will have campaigned even though there ultimately was no  
14 vote. The ETF considered that this may be an unnecessary burden on the candidates, but thought  
15 that this campaign experience and the resulting exposure of the candidate to the House would  
16 actually be beneficial to the candidate.

17  
18 If the potential newly opened position does not open but there are other open positions for the same  
19 council or the Board, an election will proceed for the existing open seats. Candidates will be  
20 offered the opportunity to withdraw their nomination prior to the vote. This will allow candidates  
21 from the same delegation to avoid potential conflicts. Conversely, all candidates may also choose  
22 to continue with the election to compete for the available positions.

23  
24 Following the implementation of electronic voting during a specified election session and the  
25 proposed new announcement process, in the unlikely event that a prior election results in a newly  
26 opened position without a nominated candidate or more positions are open than nominated  
27 candidates, the unfilled position(s) would remain unfilled until the next Annual Meeting.

28  
29 There is no perfect solution to the problem of newly opened positions, but the ETF believes this  
30 proposal will encourage candidates to announce their candidacy early, add transparency to our  
31 elections, result in more contested elections, allow delegations the opportunity to vet candidates for  
32 newly opened positions, and eliminate the distraction from policy discussion that occurs with our  
33 prior "pop-up" process.

#### 34 35 APPOINTING SELECT COUNCILS

36  
37 Careful consideration was given to the idea of appointing some or all of the currently elected  
38 council positions. Appointment would eliminate most if not all the issues of concern heard  
39 regarding elections. In addition, appointment by a nominations committee allows for careful  
40 consideration of diversity and expertise needs of a council.

41  
42 The concept of appointing members to councils has several precedents within our AMA. Current  
43 rules provide multiple methods of selecting appointed councils (CLRPD--selected by the BOT and  
44 the Speaker, COL--selected by BOT, CEJA--nominated by the President), the public member of  
45 the Board is chosen by a search committee and confirmed by the HOD, and the House  
46 Compensation Committee is a combined appointment by the President and the Speaker. These  
47 committees function well with the members selected by the current appointment process and the  
48 task force does not recommend any change in these councils.

49  
50 In addition, these various methods all enjoy a plethora of candidates for each position which is in  
51 contrast to the few candidates, often unopposed, that run for councils. This may reflect a desire by

1 some to avoid the election process which has been called into question by the resolutions that  
2 called for this report. It can be argued that more candidates would come forward if councils were  
3 appointed. Appointing one or more councils would lessen the number of interviews and remove  
4 most if not all associated campaign expenses.

5  
6 The task force believes that all officers and most council members should continue to be elected,  
7 but recommends that the Council on Constitution & Bylaws (CC&B) should be transitioned over to  
8 selection by appointment. This council, perhaps more than any other council, benefits from  
9 members with particular backgrounds and skill sets that are not always appreciated in our  
10 campaign process. For example, during interviews candidates for CC&B are rarely asked questions  
11 regarding bylaws. Over the past several elections CC&B has attracted relatively few candidates as  
12 compared to other elected councils and far fewer than appointed councils.

13  
14 Concern was expressed that service on a council often leads to future leadership positions and  
15 appointment may have a deleterious effect on the potential of council members moving forward. A  
16 review of current and recent past successful officer candidates found that there was a balance  
17 between those that had previously served on elected and appointed councils, and in fact a lower  
18 representation of past CC&B members.

19  
20 The specific process of appointment could be determined subsequently, but the task force favors a  
21 process that would include consideration by the Board of Trustees of nominated candidates with a  
22 slate for each open position presented to the House of Delegates for approval. Terms, tenure and  
23 role of the council would remain unchanged.

#### 24 25 THE ROLE AND INFLUENCE OF CAUCUSES

26  
27 Concerns about the role played by caucuses in the election process have been heard for many years,  
28 perhaps getting louder as caucuses have grown larger. There is little question that delegations and  
29 caucuses have significant influence in our elections.

30  
31 These caucuses are often the source of interviews of candidates and subsequently suggest to  
32 varying degrees voting for particular candidates. A small number of delegates (5%) in the HOD  
33 survey responded that they felt their vote was "mandated" by their delegation and others, while still  
34 a minority (15%), said they felt "strong pressure" to vote for particular candidates. Meanwhile, our  
35 current guiding principles for elections, Policy G-610.021 [*emphasis added*] clearly states –

- 36  
37 1. AMA delegates should: (a) avail themselves of all available background information about  
38 candidates for elected positions in the AMA; (b) determine which candidates are best qualified  
39 to help the AMA achieve its mission; and (c) make independent decisions about which  
40 candidates to vote for .

41  
42 Insofar as AMA's elections are conducted by secret ballot, the task force believes that delegates  
43 ought to be able to hew closely to these principles with little fear of repercussions. Further review  
44 of the survey results show that almost ⅔ of the respondents (65%) "make their own decision" with  
45 or without input from their delegation or caucus. This is not meant to suggest that delegates should  
46 ignore their sponsoring organization's endorsements, only that the sponsoring organization's  
47 recommendations are but a single element in a delegate's decision-making armamentarium with  
48 respect to elections.

49  
50 Others say they are offended by "vote trading and deals" made within and between caucuses. The  
51 ETF notes that our principles go on to state:



1       2. Any electioneering practices that distort the democratic processes of the AMA-HOD  
2       elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

3  
4       As such it seems rules already exist to address these issues. The ETF strongly recommends that  
5       these policies be reaffirmed and that efforts should be made to make delegates more aware of these  
6       principles. In addition, we recommend Principle 2 should be strengthened by adding the following:  
7       “This policy applies between as well as within caucuses and delegations.”

8  
9       Furthermore, we recommend addition of another principle to discourage delegations from using  
10      “rank order” lists of candidates and encourage delegations to provide an opportunity for their  
11      members to have an open discussion regarding candidates.

12  
13      Candidates typically seek nomination and endorsement from the groups with which they associate  
14      or with whom they have perceived connection. Some argue that this provides a desirable screening  
15      of candidates and a way to gain support. Others see this as controlling who is allowed to become a  
16      candidate and preventing some qualified individuals from entering a race. The ETF believes  
17      delegations and caucuses should have autonomy in deciding whom they support as candidates, but  
18      we emphasize that the goal of our elections should be to select the most qualified leaders for our  
19      Association. As such we propose another additional guiding principle for election as follows:

20  
21      (8) Delegations and caucuses should be a source of encouragement and assistance to qualified  
22      candidates. Nomination and endorsement should be based upon selecting the most qualified  
23      individuals to lead our AMA regardless of the number of positions up for election in a given  
24      race. Delegations and caucuses are reminded that all potential candidates may choose to run for  
25      office, with or without their endorsement and support.

26  
27      In addition, the ETF believes other recommendations within this report (recorded interviews,  
28      posted website materials, electronic communications originating from the HOD Office, etc.) will  
29      provide candidates more opportunity independent of the assistance from well funded delegations  
30      and large caucuses. Any candidate will be able to participate in the AMA reception providing them  
31      exposure without the need for a separate reception. Several other recommendations should also  
32      reduce the expense of campaigns, further reducing the influence of delegations and caucuses.

33  
34      During the task force discussions, the question was raised about the size of caucuses. That is,  
35      should the size of a caucus be capped such that its influence—whether real or perceived—does not  
36      become outsized? The task force is not making a recommendation on this matter at this time. It  
37      remains a question whether limitations on caucuses are within the House’s authority at all. The  
38      ETF recommends continued monitoring of the effects of the adopted recommendations and  
39      consideration of future changes should they be deemed necessary.

## 40 41      THE DAY OF THE ELECTIONS

42  
43      The task force heard suggestions for moving the day of the elections to earlier in the Annual  
44      Meeting, but does not favor such a change. First, determining who are the best candidates takes  
45      time, and the time devoted to interviews is valued by both candidates and the electorate. An earlier  
46      date would increase reliance on speeches and written materials rather than “getting to know” the  
47      candidates. Truncating the vetting process would be most harmful to lesser known candidates and  
48      those from smaller delegations. After examining the other days of the Annual Meeting, the ETF  
49      concluded that moving the elections would cause greater disruption to the already full agenda for  
50      each of the other days. The potential to adversely affect the elections by moving them forward

seems too great to alter the day of the elections. Therefore, the task force favors implementation of the reforms proposed herein, which we believe will address the concerns underlying proposals to move the day of elections. (See Appendix F for detailed discussion of the ETF consideration of alternative days of election.)

#### ELECTION COMMITTEE

At the open forum discussion at I-19 the idea of an ongoing election committee was proffered and received broad support. The concept was not to detract from the Speakers' role in overseeing the campaign and election process, but rather to provide them support. Recognizing that improvement in our elections is an iterative process, a committee could monitor the impacts of the recommendations adopted from this report and make further recommendations for the continued evolution of our election process. In addition, it was mentioned that enforcing campaign rules could create real or perceived bias for a Speaker if the complainant or the accused happened to be a friend or from their delegation. The committee working with the Speakers could adjudicate potential campaign violations. The Speakers are receptive to this proposal.

The ETF recommends establishment of an Election Committee of 7 individuals, appointed by the Speaker for 1-year terms to report to the Speaker. We proposed that these individuals be allowed to serve up to 4 consecutive terms but that the maximum tenure be 8 years. These individuals would agree to not be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups to reduce potential bias. The primary role of the committee would be to work with the Speaker to adjudicate any election complaint. The ETF envisions selection of a smaller subcommittee from the Election Committee to adjudicate each specific complaint. Additional roles could include monitoring election reforms, considering future campaign modifications, and responding to requests from the Speaker for input on election issues that arise. Our Bylaws (2.13.7) provide for the appointment of such a committee. This Bylaw specifies that the term may be directed by the House of Delegates. Therefore, the ETF recommends that such a committee be established for the terms noted.

In addition, the task force recommends a more defined complaint and violation adjudication process including the proposed Election Committee. Details can be further determined by the committee in consultation with the Speakers and presented to the House at a future date, but the ETF suggests consideration of a more formal process for reporting, validation of the complaint with investigation as needed, resolution of the concern and presentation to the HOD if a formal penalty (up to and including exclusion from the election) is deemed appropriate.

#### REVIEW OF IMPLEMENTATION

The above recommendations are all derived from our extensive review and deliberation of our AMA election process. These recommendations represent the consensus of the ETF and we are confident that they will lead to improvement. The House of Delegates will undoubtedly have opinions as to whether these are the right solutions but the ultimate determination will only become clear once the adopted recommendations are implemented. Therefore, our final recommendation is for a review to be conducted after an interval of 2 years led by the Speaker and at the Speaker's discretion, the appointment of another election task force, with a report back to the House.

1 CONCLUSION AND RECOMMENDATIONS

2  
3 Our AMA election process is guided by our bylaws, various policies adopted by the HOD, the  
4 HOD Reference Manual and tradition with overall responsibility resting with the Speaker. As such,  
5 the following recommendations, if adopted, will require thorough review and editing of these  
6 documents to reflect the changes.

7  
8 Following the detailed discussion above, the Election Task Force recommends that the following  
9 recommendations be adopted, with the rules to be effective upon adjournment of this meeting, and  
10 the remainder of this report be filed. Recommendations are listed in order of the topics covered in  
11 the body of the report with all modified current policies reconciled in numerical order in Appendix  
12 G for clarity.

13  
14 *Campaign Memorabilia*

15  
16 **Recommendation 1:** Campaign memorabilia may not be distributed in the Not for Official  
17 Business (NFOB) bag. (New HOD Policy)

18  
19 **Recommendation 2:** Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by  
20 addition and deletion to read as follows:

- 21  
22 (10) Campaign expenditures and activities should be limited to reasonable levels necessary for  
23 adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the~~  
24 ~~Annual Meeting in the non-official business bag and at one campaign party. Campaign~~  
25 ~~gifts should only be distributed during the Annual Meeting and not mailed to delegates and~~  
26 ~~alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall~~  
27 ~~establish a limit on allowable expenditures for campaign-related gifts. In addition to these~~  
28 ~~giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or~~  
29 ~~sticker. No other e~~Campaign memorabilia and giveaways that include a candidate's name  
30 or likeness may not shall be distributed at any time; (Modify Current HOD Policy)

31  
32 *Stickers, Buttons, and Pins*

33  
34 **Recommendation 3:** Campaign stickers, pins, buttons and similar campaign materials are  
35 disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies,  
36 state and regional delegations and health related causes that do not include any candidate identifier.  
37 These pins should be small, not worn on the badge and distributed only to members of the  
38 designated group. General distribution of any pin, button or sticker is disallowed. (New HOD  
39 Policy)

40  
41 **Recommendation 4:** Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by  
42 deletion to read as follows:

- 43  
44 (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party.  
45 However, a candidate may be featured at only one party, which includes: (a) being present  
46 in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside  
47 of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on~~  
48 ~~them.~~ At these events, alcohol may be served only on a cash or no-host bar basis; (Modify  
49 Current HOD Policy)

*Campaign Receptions*

**Recommendation 5:** Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception. (New HOD Policy)

**Recommendation 6:** Policy G-610.020, Rules for AMA Elections, paragraph 8 be reaffirmed (minus phrase “c” recommended for deletion above):

- (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on them.~~ At these events, alcohol may be served only on a cash or no-host bar basis; (Reaffirm HOD Policy)

*Dinners, Suites and Such*

**Recommendation 7:** Group dinners, if attended by an announced candidate in a currently contested election, must be “Dutch treat” - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule. (New HOD Policy)

**Recommendation 8:** Policy G-610.020, Rules for AMA Elections, paragraph 6 be amended by addition and deletion to read as follows:

- (6) At any AMA meeting convened prior to the time period for active campaigning the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting~~. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, ~~such as small group meetings, including informal dinners,~~ meant to familiarize others with a candidate's opinions and positions on issues; (Modify Current HOD Policy)

*Campaign Literature*

**Recommendation 9:** Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the “Not for Official Business” bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. (New HOD Policy)

**Recommendation 10:** Policy G-610.020, Rules for AMA Elections, paragraph 9 be amended by addition and deletion to read as follows:

- (9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured ~~parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates~~. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates; (Modify Current HOD Policy)

**Recommendation 11:** The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates. (New HOD Policy)

**Recommendation 12:** Policy G-610.020, Rules for AMA Elections, paragraph 5 be amended by addition and deletion to read as follows:

- (5) A reduction in the volume of telephone calls and electronic communication from candidates, ~~and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages; (Modify Current HOD Policy)

**Recommendation 13:** An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates. (New HOD Policy)

**Recommendation 14:** Policy G-610.020, Rules for AMA Elections, paragraph 4 be amended by addition to read as follows:

- (4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates; (Modify Current HOD Policy)

*Interviews*

**Recommendation 15:** Policy G-610.020, Rules for AMA Elections, paragraph 14 be reaffirmed:

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and (Reaffirm HOD Policy)

**Recommendation 16:** Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group. (New HOD Policy)

**Recommendation 17:** The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website. (New HOD Policy)

*Voting Process and Election Session*

**Recommendation 18:** Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker. (New HOD Policy)

**Recommendation 19:** Policy G-610.030, Election Process be amended by addition and deletion to read as follows:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House in line to vote at the time appointed to cast their electronic votes for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House. (Modify Current HOD Policy)

**Recommendation 20:** The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments. (New HOD Policy)

*Announcements and Nomination*

**Recommendation 21:** Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition to read as follows:

- (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election; (Modify Current HOD Policy)

**Recommendation 22:** Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker. (New HOD Policy)

**Recommendation 23:** Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times. (New HOD Policy)

**Recommendation 24:** Policy G-610.020, Rules for AMA Elections, paragraph 15 be reaffirmed:

- (15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Reaffirm HOD Policy)



**Recommendation 25:** Policy G-610.010, Nominations be amended by addition and deletion to read as follows:

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; (Modify Current HOD Policy)

**Recommendation 26:** Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

- (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the ~~nominees~~ candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates; (Modify Current HOD Policy)

*Newly Opened Positions*

**Recommendation 27:** The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions. (New HOD Policy)

**Recommendation 28:** If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. (New HOD Policy)

**Recommendation 29:** If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. (New HOD Policy)

**Recommendation 30:** In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting. (New HOD Policy)



**Recommendation 31:** Bylaws 3.4.2.2 and 6.8.1.5 be rescinded.

**3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

**6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted. (Modify Bylaws)

*Appointing Select Councils*

**Recommendation 32:** Members of the Council on Constitution & Bylaws (CC&B) will be appointed. The appointment process would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged. Appropriate bylaws to accomplish this change will be crafted by CC&B. (Modify Bylaws)

*The Role and Influence of Caucuses*

**Recommendation 33:** Policy G-610.021, Guiding Principles for House Elections, principle 2 be amended by addition to read as follows:

- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations. (Modify Current HOD Policy)

**Recommendation 34:** Policy G-610.021, Guiding Principles for House Elections, principles 1, 3, 4, 5 and 6 be reaffirmed:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position. (Reaffirm HOD Policy)

**Recommendation 35:** Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates. (Modify Current HOD Policy)

**Recommendation 36:** Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 8 to read as follows:

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support. (Modify Current HOD Policy)

#### *The Day of the Elections*

**Recommendation 37:** Policy G-610.030, Election Process, paragraph 1 be reaffirmed:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; ... (Reaffirm HOD Policy)

#### *Election Committee*

**Recommendation 38:** In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. (New HOD Policy)

**Recommendation 39:** The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties This process will be presented to the House for approval. (New HOD Policy)

1 **Recommendation 40:** Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by  
2 addition to read as follows:

- 3  
4 (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall  
5 administration of our AMA elections, although balloting is conducted under the  
6 supervision of the chief teller and the Committee on Rules and Credentials. The Speaker  
7 and Vice Speaker will advise candidates on allowable activities and when appropriate will  
8 ensure that clarification of these rules is provided to all known candidates. The Speaker, in  
9 consultation with the Vice Speaker and the Election Committee, is responsible for  
10 declaring a violation of the rules; (Modify Current HOD Policy)  
11

12 *Review of Implementation*  
13

14 **Recommendation 41:** After an interval of 2 years a review of our election process, including the  
15 adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's  
16 discretion the appointment of another election task force, with a report back to the House. (New  
17 HOD Policy)

Fiscal Note: Up to \$250,000 if AMA elects to sponsor a reception, depending on the number of people and food and beverage.

#### APPENDIX A – Task Force Charge and Membership

##### Policy G-610.031, Creation of an AMA Election Reform Committee

Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

## APPENDIX B – Current AMA Election Rules and Policies

### CONSTITUTION

#### Article IV House of Delegates

The House of Delegates is the legislative and policy-making body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws.

### BYLAWS

#### 3—Officers

**3.1 Designations.** The officers of the AMA shall be those specified in Article V of the Constitution.

**3.2.1 General.** An officer, except the public trustee, must have been an active member of the AMA for at least 2 years immediately prior to election.

**3.2.1.3 Restriction on Chair.** The Chair of the Board of Trustees is not eligible for election as President-Elect until the Annual Meeting following completion of the term as Chair of the Board of Trustees.

**3.3 Nominations.** Nominations for President-Elect, Speaker and Vice Speaker, shall be made from the floor by a member of the House of Delegates. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made from the floor by a member of the House of Delegates and may be announced by the Board of Trustees.

#### 3.4 Elections.

**3.4.1 Time of Election.** Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

**3.4.2 Method of Election.** Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

##### 3.4.2.1 At-Large Trustees.

**3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of

Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

**3.4.2.1.2 Runoff Ballot.** A runoff election shall be held to fill any vacancy not filled because of a tie vote.

**3.4.2.1.3 Subsequent Ballots.** If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

**3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

**3.4.2.3 All Other Officers, except the Medical Student Trustee and the Public Trustee.** All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

**3.4.2.4 Medical Student Trustee.** The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

**3.4.2.5 Public Trustee.** The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

### **3.5 Terms and Tenure.**

**3.5.1 President-Elect.** The President-Elect shall be elected annually and shall serve as President-Elect until the next inauguration and shall become President upon installation at the inaugural ceremony, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the meeting.

**3.5.2 Speaker and Vice Speaker.** The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until their successors are elected and installed.

**3.5.2.1 Limit on Total Tenure.** An individual elected as Speaker may serve a maximum tenure of 4 years as Speaker. An individual elected as Vice Speaker may serve for a maximum tenure of 4 years as Vice Speaker.

**3.5.3 Secretary.** A Secretary shall be selected by the Board of Trustees from one of its members and shall serve for a term of one year.

**3.5.4 At-Large Trustees.** At-Large Trustees shall be elected to serve for a term of 4 years, and shall not serve for more than 2 terms.

**3.5.4.1 Limit on Total Tenure.** Trustees may serve for a maximum tenure of 8 years. Trustees elected at an Interim Meeting may serve for a maximum tenure of 8 years from the Annual Meeting following their election. The limitation on tenure shall take priority over a term length for which the Trustee was elected.

**3.5.4.2 Prior Service as Young Physician Trustee.** Periods of service as the young physician trustee shall count as part of the maximum Board of Trustees tenure.

**3.5.4.3 Prior Service as Resident/Fellow Physician Trustee or Medical Student Trustee.** Periods of service as the resident/fellow physician trustee or as the medical student trustee shall not count as part of the maximum Board of Trustees tenure.

**3.5.5 Resident/Fellow Physician Trustee.** The resident/fellow physician trustee shall serve a term of 2 years and shall not serve for more than 3 terms. If the resident/fellow physician trustee is unable, for any reason, to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected to a term to expire at the conclusion of the second Annual Meeting of the House of Delegates following the meeting at which the resident/fellow physician trustee was elected.

**3.5.5.1 Cessation of Residency/Fellowship.** The term of the resident/fellow physician trustee shall terminate and the position shall be declared vacant if the trustee should cease to be a resident/fellow physician. If the trustee completes residency or fellowship within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until the completion of the Annual Meeting.

**3.5.6 Medical Student Trustee.** The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on

policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

**3.5.6.1 Term.** The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.

**3.5.6.2\ Re-election.** The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

**3.5.6.3 Cessation of Enrollment.** The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

**3.5.7 Young Physician Trustee.** The young physician trustee shall be elected for a term of 4 years, and shall not serve for more than 2 terms.

**3.5.7.1 Limitations.** No candidate shall be eligible for election or reelection as the young physician trustee unless, at the time of election, he or she is under 40 years of age or within the first eight years of practice after residency and fellowship training, and is not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

**3.5.8 Public Trustee.** A public trustee shall be elected for a term of 4 years, and shall not serve for more than one term. A public trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that a public trustee shall not have the right to vote on intra-Board elections. A public trustee shall not be eligible for election as an officer of the Board of Trustees.

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## **6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.**

**6.8.1 Nomination and Election.** Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

**6.8.1.1 Separate Election.** The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who



received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

**6.8.1.2 Other Council Members.** With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

**6.8.1.3 Run-Off Ballot.** A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

**6.8.1.4 Subsequent Ballots.** If all vacancies are not filled on the first ballot and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee. This procedure shall be repeated until all vacancies have been filled.

**6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.

**6.8.2 Medical Student Member.** Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

**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.**

**6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member.** Members of these Councils other than the

resident/fellow physician and medical student member shall be elected for terms of 4 years.

**6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician member of these Councils shall be elected for a term of 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.

**6.9.1.3 Medical Student Member.** The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

**6.9.2 Tenure.** Members of these Councils may serve no more than 8 years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting.

### **6.9.3 Vacancies.**

**6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member.** Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

**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 3-year term. 6.10 Commencement of Term. Members of Councils who are elected by the House of Delegates shall assume office at the close of the meeting at which they are elected.

## **POLICIES**

### **Policy G-610.010, Nominations**

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of nominations to the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should

list candidates in alphabetical order by name only; and (5) nominating speeches for unopposed candidates for office, except for President-elect, should be eliminated.

Policy G-610.020, Rules for AMA Elections

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;

(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

(6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only"

section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

#### Policy G-610.021, Guiding Principles for House Elections

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
- (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
- (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
- (6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

#### Policy G-610.030, Election Process

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

## **APPENDIX C – Resolutions submitted at the 2019 Annual Meeting**

### **RESOLUTION 603-A-19**

Whereas, Members of our AMA House of Delegates cherish our democratic process; and

Whereas, Our current election and voting process for AMA officers and council positions consumes a lot of time and financial resources; and

Whereas, Election reform would allow for more time for policy and debate during HOD sessions; and

Whereas, Cost barriers are often an impediment to candidate elections; and

Whereas, There are significant technological advances that could allow for an expedited process of elections and debate; therefore be it

RESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions; and be it further

RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:

- The creation of an interactive election web page;
- Candidate video submissions submitted in advance for HOD members to view;
- Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions;
- Move elections earlier to the Sunday or Monday of the meeting;
- Conduct voting from HOD seats; and be it further

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns; and be it further

RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations.

### **RESOLUTION 611-A-19**

Whereas, There is an arms race in terms of the number of emails, social media posts, handwritten notes and mailers which consumes thousands of hours of time when candidates and their team could be participating in online testimony and preparing for the AMA meeting; and

Whereas, Our candidates attend up to 30 interviews across the Federation consuming at least 5 hours of interview time alone not including traveling time; and

Whereas, Most have an “entourage” of 2 to 15 people which means that at least 10-75 hours of time is taken from their participation in their delegation deliberations and debate; and

Whereas, For the elections in 2018 with 24 people running in competitive elections this amounted to about 1800 hours of lost time at the meeting; and

Whereas, This time is a gross underestimation of the time involved given the walking between sessions; and

Whereas, This does not take into account the time taken from each delegation to participate in the interview process and the time spent waiting for candidates; and

Whereas, Candidates and campaign teams remain distracted by their campaigns throughout the reference committees and even during the business of the House of Delegates; and

Whereas, Even after the primary election, runoffs can consume a tremendous amount of time since they are done with paper; and

Whereas, Sponsoring societies spend extensive resources in the form of time and money to support their individual candidates; and

Whereas, Many qualified candidates from the House of Delegates have chosen not to run campaigns because the burden in terms of money and manpower are prohibitive; and

Whereas, The election process has not been updated in several years despite both our House otherwise going paperless and additional security and technology advancements during that time; and

Whereas, Many specialty societies already hold web-based or device-based elections with no perceived violation of security or confidence in the outcome; therefore be it

RESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making; and be it further

RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

- a. Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
- b. Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
- c. Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)
- d. An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.
- e. Electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.
- f. Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.

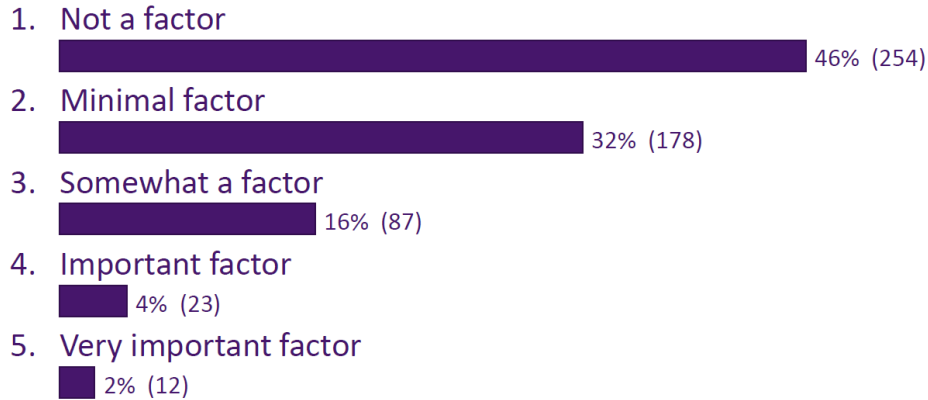
- g. Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it further

RESOLVED, That the task force report back to the HOD at the 2019 Interim Meeting.

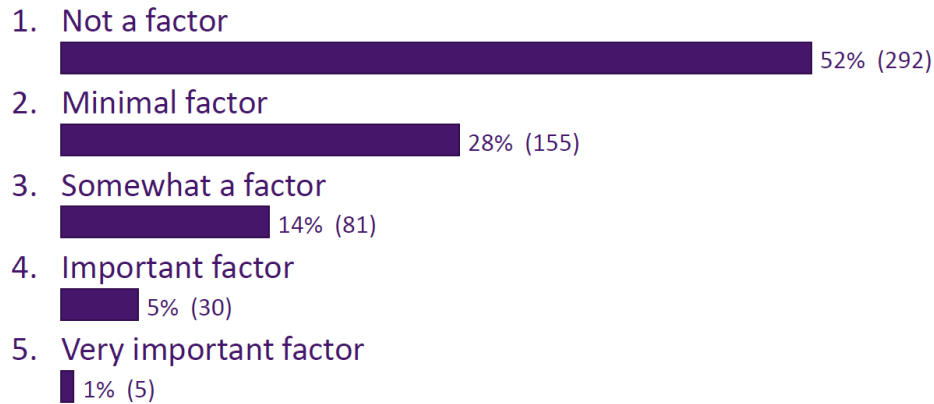


## APPENDIX D – Questions and responses from I-19 survey of the House of Delegates

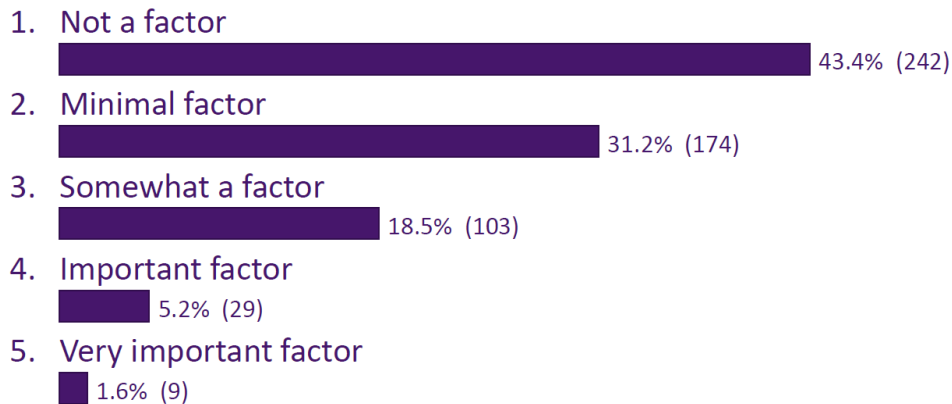
In determining your vote, how much of a factor are campaign brochures in the “Not For Official Business” bag?



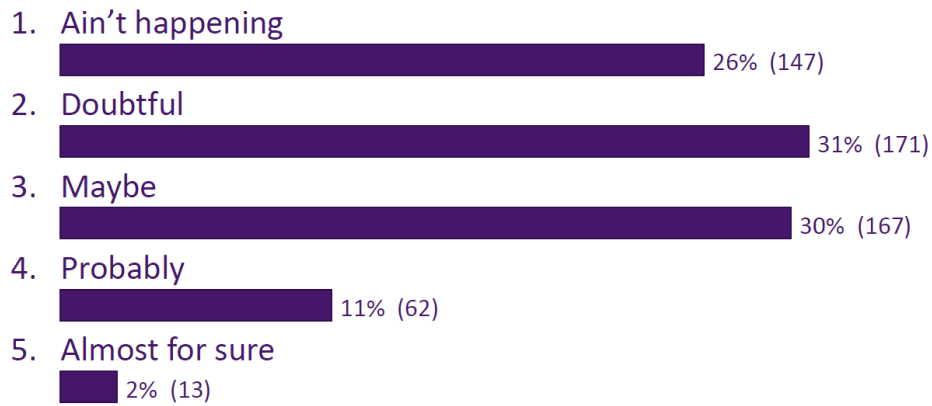
In determining your vote, how much of a factor are campaign brochures mailed to you before the meeting?



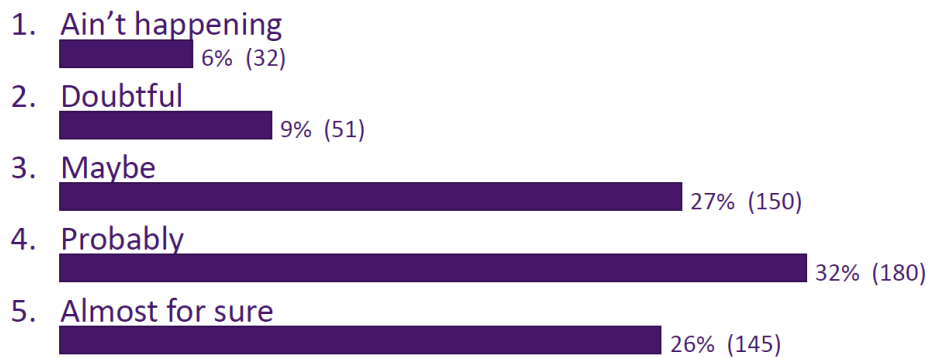
In determining your vote, how much of a factor are campaign materials emailed to you before the meeting?



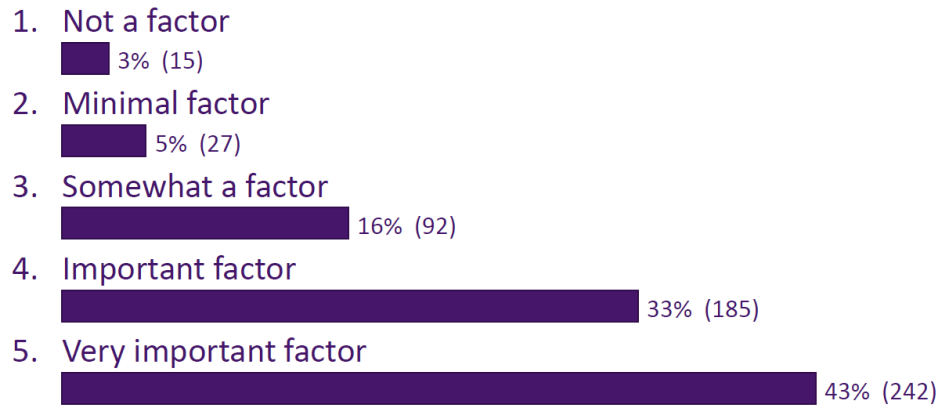
How likely are you to look at candidates' websites?



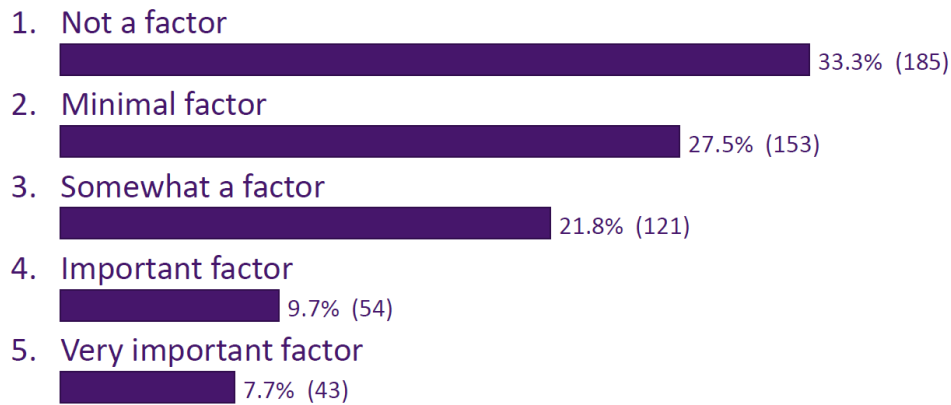
How likely are you to look at an enhanced AMA Elections website that would include links to the candidates' website and answers to specific questions given to candidates in advance?



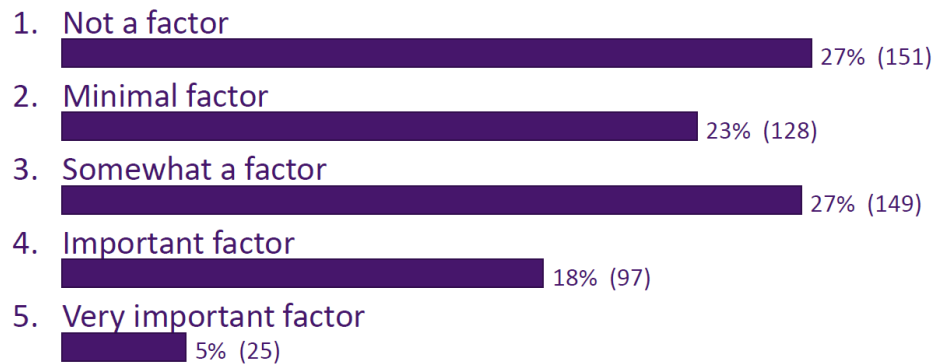
In determining your vote, how much of a factor is the interview process?



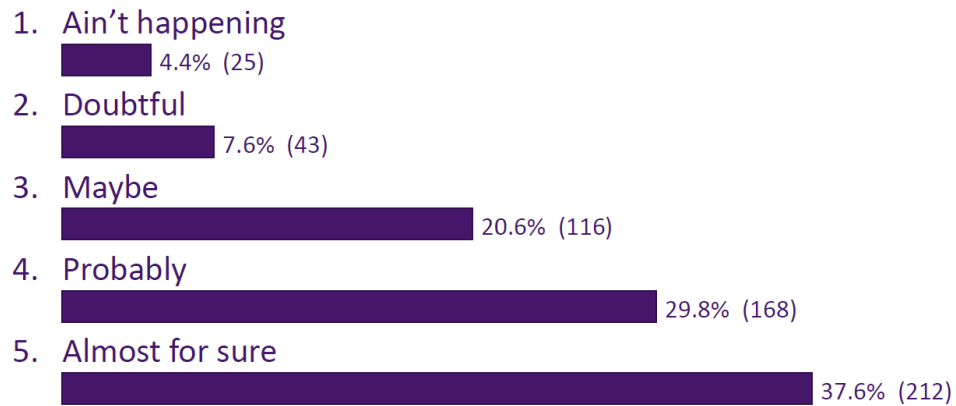
In determining your vote, how much of a factor are campaign receptions?







In determining your vote, how much of a factor are small group dinners and/or gatherings in suites at Interim, State Advocacy and NAC?








Would you attend a combined candidates party?



### After a seat opens on the BOT or a council, how should the open seat be filled?

1. Open the floor for nominations, give speeches, and hold elections immediately (current process)  
 43% (228)
2. Hold the seat/s open until the next Interim meeting and elect at that meeting  
 26% (139)
3. Hold the seat/s open until the next Annual meeting elections  
 12% (63)
4. Require candidates to vacate their current position at the time of elections, regardless of the outcome  
 19% (99)

### Which statement most accurately reflects the influence your delegation or caucus has on your vote?

1. I receive no guidance from my delegation or caucus regarding elections  
 4% (23)
2. I get input from my caucus or delegation, but make my own decision  
 61% (342)
3. I feel somewhat pressured to vote for particular candidates selected by my caucus or delegation  
 15% (82)
4. I am strongly pressured by my delegation or caucus to vote for certain candidates  
 15% (85)
5. My vote is mandated by my caucus or delegation  
 5% (29)

## **Appendix E - Newly Opened Positions - Options Considered**

Three potential solutions for newly created vacancies (“pop-ups”) were initially considered: requiring candidates seeking another office to resign their current position; leaving the open seat vacant until the following Annual Meeting; and modifying the procedures for handling new vacancies. Each of these options were discussed at the I-19 Open Forum and were the subject of a question on the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. The first two options would require bylaws changes. Ultimately the ETF developed a new fourth option based upon newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation which eliminates most of the problems associated with “pop-ups” without necessitating the more radical changes associated with any of the three options presented at I-19. **Below is a discussion of each of the options that were considered, three of which are not recommended.**

Requiring candidates to resign their current positions would address the problematic aspects of these “pop-up” elections. Because all vacancies would be known well in advance, elections could proceed as usual, without additional nominations or speeches, candidates would be known in advance to allow time for proper vetting through the usual interview process, and the possibility of opening a new seat on a council would no longer be a consideration in voting as the seat would be open regardless of the election outcome. To be clear, the incumbent seeking a new position would not resign until the close of the Annual Meeting at which the elections took place, which is when all newly elected officials take office. Questions about the fairness of such a requirement arose, particularly as some officer positions open relatively infrequently as is the case for the offices of Speaker and Vice Speaker, which while elected annually, tend to come open only every four years. In addition, this would potentially mean the tenure of some of our most talented council members (those that feel qualified to seek higher office) would be truncated or alternatively, council members would delay running for higher office until serving their full tenure thus reducing opportunities for new council members and reducing candidates running for higher office. In addition, at the trustee level, this would likely discourage current trustees from running for president-elect “early” and may lead to less contested races for the president-elect position. Some commented in favor of this option, but many found the idea of forcing candidates to resign from current positions in order to run unacceptable. Another concern is whether this requirement would just be implemented for current members of elected councils or would it also apply to members of appointed councils and the Board - either creating a disparity or forcing even more resignations. In the end, the ETF felt this option pressed an unacceptable dichotomy - of the loss of tenured leaders or elected members consistently staying for their full term with less opportunity for new leaders and fewer contested elections.

The second option, namely leaving the vacancy until the following meeting was supported by some during the Open Forum and on the survey. The bylaws treat vacancies arising from the resignation or death of an officeholder differently than election-related vacancies, which suggests it is not the vacancy per se that generates concerns. Twice in the past eleven years a member of the Board of Trustees resigned and created a vacancy lasting several months. For a vacancy that occurred in the spring, the Board did not feel it necessary to appoint a trustee as permitted under AMA's bylaws, and for a vacancy that arose in the fall, neither the Board nor the Committee on Rules and Credentials thought a special election was needed. Vacancies on the elected councils remain unfilled until elections are held at the next Annual Meeting (see Bylaw 6.9.3.1). As a practical matter none of the elected councils has experienced a vacancy in the last 13 years, so it is difficult to judge if a vacancy would undermine the council's effectiveness. Recently 2 members with

unexpired terms on a single council ran for the Board. Would different rules be necessary to handle the situation where multiple seats were vacant vs. a single seat? It was unclear how to handle term and tenure of members elected at the half year and the ETF wanted to keep the Interim Meetings free of elections, so any vacancy would remain for a full year until the next Annual Meeting. Informal discussion with current and past council members suggested that vacancies while not untenable would be undesirable.

The third option discussed, altering the procedures for handling new vacancies, takes two forms. One possibility would be to take nominations immediately after the vacancy is announced, have the nominees make necessary speeches immediately and then move at once to voting. This would address concerns about electioneering and vote trading but further reduces opportunity to vet the candidates. The other possibility would be to call for nominations immediately but to delay voting to the next day, which would currently be Wednesday. This would permit the possibility of interviews, but Tuesday is a full day and the inauguration is Tuesday night, making it unlikely many would interview the candidates. It is also conceivable that a meeting that would otherwise adjourn on Tuesday because the business had been accomplished would have to carry over to the next morning solely for elections. (The task force believes that speedier elections might lead to a Tuesday adjournment; see "Technology" below.) The ETF did not favor moving the date of the main elections from Tuesday and even if moved to Monday with "pop-ups" on Tuesday this would mean elections would be the focus of two HOD sessions contrary to the goal to lessen the distraction from policy deliberation.

The ETF favored a process that encouraged or required candidates to announce their intention to run for potentially newly opened positions but avoided the negatives of the previously discussed options. To accomplish this, members would have to be alerted to potential openings and then allowed to join the campaign. Some would argue that candidates already "announce" that they intend to run if a seat opens just not officially. Formalizing this announcement process would provide greater transparency. Presumably, this would mean more interviews. Likely, these candidates would not go to the same expense and effort of a regular campaign (seen as one of the advantages of being a pop-up). In studying options for use of technology to expedite voting (another specific charge of the ETF), the ETF discovered a novel solution to this issue, as presented in the main body of this report and recommended.

## **Appendix F - Day of Elections - Options Considered**

The following is the ETF discussion regarding moving the day of the elections to an alternative day/time. After the review detailed below, the ETF recommended continuing elections on Tuesday morning while instituting other reforms including electronic voting and the "Election Session."

One of the specific requests of Resolutions 603-A19 and 611-A19 which established the ETF, was to consider moving the day/date of the elections earlier, arguing that this would reduce the number of receptions, interviews, disruption of policy consideration and overall reduce the focus of the meeting away from elections to policy. Current rules specify elections will be on Tuesday (time is determined by Speaker) so a rule change would be required.

### **Options:**

Move elections to Interim - fewer delegates attend. Shorter meeting. Geographic bias in any given year may affect attendance and outcome. Terms of office begin when? Councils and BOT use annual to annual as their planning cycle. This would politicize the interim meeting. Would not correct the concern regarding the "distraction from policy discussion" and may extend the length of Interim meeting.

Saturday voting – little time to meet candidates, particularly lesser known or from small delegations. Vetting process would be truncated or if in-person interviews are to continue, they would likely need to be moved to Friday morning or even Thursday (lengthening the meeting for candidates and interviewers). Would increase reliance on the 2-minute speech before HOD. Less opportunity for interaction with candidates. Potentially less informed voters. Seems to carry many of the disadvantages of "pop ups" which many have spoken against. Saturday is the first day the House convenes and nominations occur this day. Nominations "from the floor" are allowed by our rules - if a candidate is nominated on Saturday and then voting occurs there would be no opportunity to vet that candidate.

Sunday voting – already a very full day. Brief HOD session then reference committee hearings all day. Voting would lengthen the HOD session and delay the start of reference committees; thus, the reports which already take well into the early morning to prepare so they can be reviewed by the delegates would be delayed as well. Little time to vet candidates without moving interviews forward. Receptions would simply start a night earlier.

Monday voting – morning is filled with caucus meetings to review reference committee reports. Moving HOD session start time forward to allow time for elections would reduce time for policy discussion in and among delegations. Monday is already a short day of policy debate (typically 3.5 hrs or less) and provides some insight into remaining business. Some delegates prioritize the elections and might even go home if their candidate is unsuccessful. Would unsuccessful candidates awkwardly continue at the meeting? Would the afternoon be spent with congratulations to the winners (which often takes place at the President's reception Tuesday night), distracting from policy debate? If we move the President's inaugural and dinner to Monday, as has been suggested, the afternoon would need to end by 3 or so (likely meaning minimal or no policy discussion time that day).

Tuesday voting – keep current day but improve the process using technology and rules to expedite the voting including runoffs. Eliminate "pop-up" elections and the associated speeches. Designate an election session early morning with HOD resuming business afterwards lessening the concern

for distraction and interruption of policy debate. Provides maximum time for vetting the candidates. Allows for the President's reception to continue as scheduled on Tuesday night.



## **Appendix G – Reconciliation of Policies Related to Elections**

### **Policy G-610.010, Nominations**

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to applications for consideration by the Board of Trustees at their April meeting for~~ the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

### **Policy G-610.020, Rules for AMA Elections**

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker ~~and the Election Committee~~, is responsible for declaring a violation of the rules;

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. ~~Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning.~~ The Speakers may use additional means to make delegates aware of those members intending to seek election;

(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the ~~nominees candidates~~ for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. ~~The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed.~~ The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring

before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls and electronic communication from candidates; ~~and literature and letters by or and~~ on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages;

(6) At any AMA meeting convened prior to the time period for active campaigning the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting~~. It is permissible ~~at the Interim Meeting~~ for candidates seeking election to engage in individual outreach, ~~such as small group meetings, including informal dinners~~, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured ~~parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates~~. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other e~~Campaign memorabilia and giveaways that include a candidate's name or likeness may not ~~shall~~ be distributed at any time;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

#### **Policy G-610.021, Guiding Principles for House Elections**

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates.

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

#### **Policy G-610.030, Election Process**

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House in line to vote at the time appointed ~~to cast their electronic votes for the close of polls;~~ and (3) The final vote count of all

secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(JUN-21)

Introduced by: New York

Subject: Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The ongoing overdose crisis has spared no demographic, professional, or geographic  
2 stratum, and although efforts to bring substance use disorder and its treatment out of the  
3 shadows have made substantial inroads, outdated thinking, policies, and practices persist; and  
4

5 Whereas, Opioid-agonist therapy is the standard treatment for opioid use disorder (OUD) and  
6 maintenance with methadone or buprenorphine sharply reduces the risks of relapse, overdose,  
7 and death, making it possible for patients to regain control of their personal and occupational  
8 functions; and  
9

10 Whereas, Despite the well-documented effectiveness of such MAT (medication assisted  
11 treatment), however, MAT for opioid use disorder remains vastly underutilized in the United  
12 States and elsewhere; and  
13

14 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine  
15 concluded that “there is no scientific evidence that justifies withholding medications from OUD  
16 patients in any setting” and stated that such practices amount to “denying appropriate medical  
17 treatment”; and  
18

19 Whereas, The American Society of Addiction Medicine recommends that “Healthcare  
20 professionals should be offered the full range of evidence-based treatment, including medication  
21 for addiction, in whatever setting they receive treatment; and  
22

23 Whereas, Physicians have a 15-20% lifetime risk of psychiatric or substance use disorder; and  
24

25 Whereas, Despite the evidence for effectiveness, doctors themselves are often prevented  
26 access to opioid agonist therapy due to policies and/or practices of physicians health and  
27 wellness programs, state medical boards, hospital and health system credentialing bodies, and  
28 employers which prevent such access; therefore be it  
29

30 RESOLVED, That our American Medical Association affirm that no physician or medical student  
31 should be presumed to be impaired by substance or illness solely because they are diagnosed  
32 with a substance use disorder (New HOD Policy); and be it further  
33

34 RESOLVED, That our AMA affirm that no physician or medical student should be presumed  
35 impaired because they and their treating physician have chosen medication for opioid use  
36 disorder (MOUD) to address the substance use disorder, including methadone and  
37 buprenorphine (New HOD Policy); and be it further

1 RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness  
2 programs, state medical boards, hospital and health system credentialing bodies, and  
3 employers to help end stigma and discrimination against physicians and medical students with  
4 substance use disorders and allow and encourage the usage of medication for opioid use  
5 disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as  
6 determined by the physician or medical student (as patient) and their treating physician, without  
7 penalty (such as restriction of privileges, licensure, ability to prescribe medications or other  
8 treatments, or other limits on their ability to practice medicine), solely because the physician's or  
9 medical student's treatment plan includes MOUD (Directive to Take Action); and be it further

10  
11 RESOLVED, That our AMA survey physician health programs and state medical boards and  
12 report back about whether they allow participants/licensees to use MOUD without punishment,  
13 or exclusion from practicing medicine or having to face other adverse consequences. (Directive  
14 to Take Action)

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

Received: 04/23/21

#### AUTHOR'S STATEMENT OF PRIORITY

Over 15% of physicians have/will have a substance use disorder over their lifetimes. For those whose substance use disorder includes opioid use disorder (OUD), the stigma and fear of being labeled as impaired by the condition, or impaired by treatment with opioid agonist therapy, greatly increases the risk that such docs or students will not enter treatment or that treatment will fail. The AMA has spoken loudly and clearly about the need for more access to MOUD for our patients because we know this affords them the best chance for success and reduces the risk of overdose death.

We cannot let another year go by without speaking loudly for needed access to MOUD for our peers. If we don't consider, discuss and act on this resolution in June 2021, then the risk will be further delays in access to appropriate care for students and physicians with OUD. This results in much higher risk of relapse, loss of license, career, family, and even loss of life by accidental overdose, suicide or death from complications or comorbidities with OUD. Patients who may be receiving their healthcare and in treatment with these physicians would lose access to their doctors if that happened. These possibilities are entirely avoidable if their physicians are successfully provided with effective treatment.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002  
(JUN-21)

Introduced by: American College of Cardiology, American Society of Echocardiography,  
Society for Cardiovascular Angiography and Interventions,  
Society of Cardiovascular Computed Tomography, American Society of  
Nuclear Cardiology

Subject: Sharing Covid-19 Resources

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The severe acute respiratory syndrome coronavirus 2 (COVID-19) has spread  
2 globally, causing nearly 3 million deaths worldwide since first appearing in 2019; and  
3

4 Whereas, We express our condolences to all individuals affected by COVID-19 and their  
5 families and friends; and  
6

7 Whereas, We are grateful for the monumental efforts and sacrifices made by health care  
8 professionals, public health workers, research scientists, pharmaceutical companies,  
9 government workers, elected officials and others for their continuing contributions in battling this  
10 pandemic; and  
11

12 Whereas, The phenomenal speed with which effective vaccines against this virus was made  
13 possible by basic research grants from the National Institutes of Health and other public  
14 institutions, further developed and rapidly manufactured in large quantities by investor-owned  
15 pharmaceutical companies; and  
16

17 Whereas, Death and other serious complications of COVID infection are more common in  
18 individuals with underlying heart disease, diabetes, hypertension and other chronic illnesses;  
19 and  
20

21 Whereas, The COVID pandemic has unmasked pre-existing severe socioeconomic and racial  
22 disparities in the delivery of health care in the United States; and  
23

24 Whereas, The public health crisis related to the COVID pandemic is even more deadly in many  
25 less economically developed countries around the world; and  
26

27 Whereas, COVID vaccine is soon to be available to all Americans desiring to be vaccinated; and  
28

29 Whereas, COVID variants continue to appear both in the US and abroad, threatening repeated  
30 surges of COVID infections, particularly in those who do not have access to vaccination; and  
31

32 Whereas, Resurgence of COVID-19 anywhere in the world potentially affects the United States;  
33 and  
34

35 Whereas, There is a moral and ethical imperative to provide effective medical care to all  
36 patients regardless of their economic status or citizenship; therefore be it

1 RESOLVED, That our American Medical Association call for the cooperation of all governments  
 2 and international agencies to share data, research and resources for the production and  
 3 distribution of medicines, vaccines and personal protective equipment (Directive to Take  
 4 Action); and be it further

5  
 6 RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health  
 7 care agencies in other parts of the world to be administered to individuals who can't afford them.  
 8 (Directive to Take Action)

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

Received: 05/03/21

#### AUTHORS STATEMENT OF PRIORITY

The COVID 19 pandemic is seminal public health threat of the past century, of vital importance to all physicians and all patients worldwide. The AMA should continue and expand its leadership role in this arena, particularly updating its policy on the worldwide, equitable distribution of vaccines and other measures which are critical to combating the pandemic.

#### **RELEVANT AMA POLICY**

##### **An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921**

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Citation: Res. 408, I-20

##### **Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979**

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.



5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

Citation: Alt. Res. 404, I-20

**World Health Organization H-250.992**

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.

Citation: BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16; Reaffirmed: BOT Rep. 23, A-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, “Racism” refers to an organized system, rooted in an ideology of inferiority that  
2 categorizes, ranks and differentially allocates societal resources to human population  
3 groups<sup>i</sup>; and  
4

5 Whereas, Racism may or may not be accompanied by prejudice at the individual level<sup>i</sup>; and  
6

7 Whereas, Explicit bias refers to the attitudes or beliefs we have about a person or group on a  
8 conscious level and includes the “-isms” such as racism, sexism, etc held by individuals<sup>ii</sup>; and  
9

10 Whereas, Implicit or unconscious bias refers to ingrained habits of thought that lead to errors in  
11 how we perceive, reason, remember and make decisions and that are unconscious or  
12 unintentional and may or may not align with our stated values or beliefs<sup>ii</sup>; and  
13

14 Whereas, Microaggressions are brief, commonplace, daily verbal, behavioral, or environmental  
15 indignities, whether intentional or unintentional, that communicate hostile, derogatory, or  
16 negative slights and insults toward marginalized populations, that implicitly communicate or at  
17 least engender hostility<sup>iii</sup>; and  
18

19 Whereas, Microaggressions are very real forms of racism and discrimination, a “persistent daily  
20 low hum of racist abuse” that is not minor or micro in how it is experienced<sup>iii</sup>; and  
21

22 Whereas, Microaggressions generate stresses equal to or worse than overt discrimination for  
23 underrepresented minority groups<sup>iv</sup>; and  
24

25 Whereas, Recent research shows that regular exposure to perceived discrimination of any kind  
26 adversely affects the psychological and physical health of the recipients including depression,  
27 anxiety, burnout, trauma response, alcohol use, among others<sup>iv,v</sup>; and  
28

29 Whereas, Patients tend to be in vulnerable states when seeking medical treatment and may be  
30 especially susceptible to psychological distress in response to racism or bias; and  
31

32 Whereas, Racism in any form is especially detrimental when enacted by health care  
33 providers; and  
34

35 Whereas, Many instances of racism and bias will likely stay unrecognized unless an ongoing  
36 intentional, reflective, and process-oriented practice is implemented; and

Whereas, Examining racism and bias should be viewed as a growth promoting, educational opportunity that has the potential to improve individual interactions and system level practices; therefore be it

RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

#### GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders

1 should work with all stakeholders to ensure safe, discrimination-free work  
2 environments within their institutions.

3  
4 Tactics to help create this type of organizational culture include:

- 5 • Surveying staff, trainees and medical students, anonymously and confidentially  
6 to assess:
  - 7 – Perceptions of the workplace culture and prevalence of discrimination,  
8 systemic racism, explicit and implicit bias and microaggressions.
  - 9 – Ideas about the impact of this behavior on themselves and patients.
- 10 • Integrating lessons learned from surveys into programs and policies.
- 11 • Encouraging safe, open discussions for staff and students to talk freely about  
12 problems and/or encounters with behavior that may constitute discrimination,  
13 including racism, bias or microaggressions.
- 14 • Establishing programs for staff, faculty, trainees and students, such as  
15 Employee Assistance Programs, Faculty Assistance Programs, and Student  
16 Assistance Programs, that provide a place to confidentially address personal  
17 experiences of discrimination, systemic racism, explicit or implicit bias or  
18 microaggressions.
- 19 • Providing designated support person to confidentially accompany the person  
20 reporting an event through the process. (New HOD Policy)

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

Received: 05/07/21

#### AUTHORS STATEMENT OF PRIORITY

Racism, or discrimination based on race or ethnicity is responsible for increasing disparities in physical and mental health among Black, Indigenous, and people of color. We feel that this resolution is a top priority for this meeting as it will provide policy for our AMA's new three-year roadmap to embed racial justice and advance health equity within the AMA and our health care system.

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<sup>i</sup> Bonilla-Silva E. Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review*. 1996;62(3):465–480.

<sup>ii</sup> Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271-286.

<sup>iii</sup> Kendi, I. X. (2019). *How to be an antiracist*. New York: One World.

<sup>iv</sup> Solorzano D, Ceja M, Yosso T. Critical race theory, racial microaggressions, and campus racial climate: the experiences of African American college students. *J Negro Educ*. 2001;69(1/2):60-73.

<sup>v</sup> Nadal KL, Wong Y, Griffin KE, Davidoff K, Sriken J. The adverse impact of racial microaggressions on college students' self-esteem. *J Coll Student Dev*. 2014;55(5):461-474.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(JUN-21)

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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1 Whereas, Based on a review of the foundational reports leading to the development of  
2 resident/fellow Council and BOT positions, the purpose of these roles is to maintain a resident  
3 voice in these bodies and to allow for residents and fellows to both gain experience in the  
4 election process and contribute meaningfully to practices of the Councils and BOT; and  
5

6 Whereas, BOT Report A at the 1976 AMA Annual Convention, which codified resident and non-  
7 voting medical student representation on the Councils with three-year term lengths and a  
8 maximum three-term limit for the Council on Medical Education (CME), Council on Medical  
9 Service (CMS), Council on Scientific Affairs, and CLRPD; and  
10

11 Whereas, Starting at the 1991 Annual Meeting, AMA House of Delegates Resolution 202  
12 "Leadership Opportunities in the American Medical Association" called for a review of the AMA  
13 Board and Councils to increase the rate of involvement of, "various demographic segments of  
14 the AMA physician population in AMA leadership" and the subsequent study period yielded a  
15 survey of AMA members showing, "57% favored reducing the maximum tenure of Council  
16 members"; and  
17

18 Whereas, During the 1996 Interim Meeting of the AMA, the Council on Long Range Planning  
19 and Development (CLRPD) presented Report 2 "Terms of Service of AMA Councils" which  
20 discussed some of the history of Council term lengths and presented arguments for and against  
21 one-, three-, five-, and seven-year terms for AMA Councils, considering "(a) the frequency of  
22 campaigns for Council positions, (b) the responsiveness of Council members to the AMA  
23 membership, the House and the Board, (c) opportunities to replace Council members whose  
24 performance is problematic, and (d) compatibility with the maximum total number of years that  
25 individuals can serve on each Council"; and  
26

27 Whereas, The CLRPD I-96 Report 2 noted that shorter terms would lead to increased member  
28 responsiveness and ease in removal of ineffective Council members, but increase time and cost  
29 devoted to campaigns, while shorter terms would be better suited for task-oriented Councils  
30 such as the Council on Legislation (COL); and  
31

32 Whereas, The RFS has concerns that three-year resident/fellow Council positions would  
33 disproportionately inhibit members of specialties with shorter residency training periods from  
34 being represented, including Internal Medicine, Emergency Medicine, Pediatrics and Family  
35 Medicine; and  
36

37 Whereas, Due to current term lengths residents/fellows in longer training programs are  
38 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 23 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 23-year term. (Modify Bylaws) and be it further

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

3 **6.6 Council on Long Range Planning and Development.**

4 **6.6.3 Term.**

5 **6.6.3.2 Resident/Fellow Physician Member.** The resident/fellow physician  
6 member of the Council shall be appointed for a term of 23 years beginning at the  
7 conclusion of the Annual Meeting provided that if the resident/fellow physician  
8 member ceases to be a resident/fellow physician at any time prior to the  
9 expiration of the term for which appointed except as provided in Bylaw 6.11, the  
10 service of such resident/fellow physician member on the Council shall thereupon  
11 terminate, and the position shall be declared vacant.

12 **6.6.5 Vacancies.**

13 **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician  
14 member of the Council ceases to complete the term for which appointed, the  
15 remainder of the term shall be deemed to have expired. The successor shall be  
16 appointed by the Speaker of the House of Delegates for a 23-year term. (Modify  
17 Bylaws) and be it further

18  
19 RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion  
20 to read as follows:

21 **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical**  
22 **Education, Council on Medical Service, and Council on Science and Public Health.**

23 **6.9.1 Term.**

24 **6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician  
25 member of these Councils shall be elected for a term of 23 years. Except as  
26 provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a  
27 resident/fellow physician at any time prior to the expiration of the term for which  
28 elected, the service of such resident/fellow physician member on the Council  
29 shall thereupon terminate, and the position shall be declared vacant.

30 **6.9.3 Vacancies.**

31 **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician  
32 member of these Councils ceases to complete the term for which elected,  
33 the remainder of the term shall be deemed to have expired. The successor  
34 shall be elected by the House of Delegates for a 23-year term. (Modify  
35 Bylaws)

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

Received: 05/10/21

**AUTHOR'S STATEMENT OR PRIORITY**

The Council on Constitution and Bylaws has indicated support for this policy change, but it requires approval by the HOD. This is crucial to the proper functioning of our RFS leadership and affects elections at this HOD and RFS elections at Interim. Residents and fellows make decisions about leadership and involvement based on time left in training and this change will directly affect our members immediately.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005  
(JUN-21)

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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1 Whereas, The average age at completion of medical training in the United States is  
2 approximately 31.6 years overall<sup>1</sup> and 36.8 years for surgical trainees<sup>2</sup>; and  
3

4 Whereas, Female fertility is known to decrease substantially after age 35,<sup>3,4</sup> with a nearly 50%  
5 drop from the early 20s to late 30s<sup>5</sup>; and  
6

7 Whereas, Female physicians have a chance of infertility that is twice that of the general  
8 population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years<sup>1</sup>; and  
9

10 Whereas, The demands of residency increase the risk of pregnancy complications, with a higher  
11 rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth  
12 restriction among female residents<sup>6-8</sup>; and  
13

14 Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during  
15 training<sup>9</sup> and have concerns about workplace support,<sup>10</sup> which may deter medical students from  
16 choosing a career in a surgical or other field with longer and demanding training; and  
17

18 Whereas, Approximately one third of program directors have reported discouraging pregnancy  
19 among residents in surgical training programs<sup>10</sup>; and  
20

21 Whereas, Oocyte cryopreservation is an established method of preserving fertility<sup>11</sup> that can  
22 cost \$10,000 per cycle, often with multiple cycles required, and \$500 per year for storage,<sup>12</sup> in  
23 addition to requiring timely injection of ovarian stimulation medications and numerous outpatient  
24 visits for cycle monitoring and egg retrieval<sup>13</sup>; and  
25

26 Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte  
27 cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for  
28 several years<sup>14</sup>; therefore be it  
29

30 RESOLVED, That our American Medical Association support education for residents and  
31 fellows regarding the natural course of female fertility in relation to the timing of medical  
32 education, and the option of fertility preservation and infertility treatment (Directive to Take  
33 Action); and be it further  
34

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



- 1 RESOLVED, That our AMA support the accommodation of residents and fellows who elect to  
 2 pursue fertility preservation and infertility treatment, including the need to attend medical visits  
 3 to complete the oocyte preservation process and to administer medications in a time-sensitive  
 4 fashion. (Directive to Take Action)

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

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. This policy applies to current and all future physician trainees.

1. Stentz NC, Griffith KA, Perkins E, Jones RD, Jaggi R. Fertility and childbearing among American female physicians. *J Womens Health*. 2016;25(10):1059-1065.
2. Jeekel J. Crucial times for general surgery. *Ann Surg*. 1999;230(6):739.
3. Gilbert WM, Nesbitt TS, Danielsen B. Childbearing beyond age 40: Pregnancy outcome in 24,032 cases. *Obstet Gynecol*. 1999;93(1):9-14.
4. Cleary-Goldman J, Malone FD, Vidaver J, et al. Impact of maternal age on obstetric outcome. *Obstet Gynecol*. 2005;105(5 Pt 1):983-990.
5. Dunson DB, Colombo B, Baird DD. Changes with age in the level and duration of fertility in the menstrual cycle. *Hum Reprod Oxf Engl*. 2002;17(5):1399-1403.
6. Grunebaum A, Minkoff H, Blake D. Pregnancy among obstetricians: A comparison of births before, during, and after residency. *Am J Obstet Gynecol*. 1987;157(1):79-83.
7. Behbehani S, Tulandi T. Obstetrical complications in pregnant medical and surgical residents. *J Obstet Gynaecol Can*. 2015;37(1):25-31.
8. Klevan JL, Weiss JC, Dabrow SM. Pregnancy during pediatric residency. Attitudes and complications. *Am J Dis Child*. 1990;144(7):767-769.
9. Turner PL, Lumpkins K, Gabre J, Lin MJ, Liu X, Terrin M. Pregnancy among women surgeons: Trends over time. *Arch Surg*. 2012;147(5).
10. Garza RM, Weston JS, Furnas HJ. Pregnancy and the plastic surgery resident. *Plast Reconstr Surg*. 2017;139(1):245-252.
11. Practice Committees of American Society for Reproductive Medicine, Society for Assisted Reproductive Technology. Mature oocyte cryopreservation: A guideline. *Fertil Steril*. 2013;99(1):37-43.
12. Cost of Egg Freezing. USC Fertility. <https://uscfertility.org/egg-freezing/cost/>. Accessed June 14, 2019.
13. The Egg Freezing Process. USC Fertility. <https://uscfertility.org/egg-freezing/egg-freezing-process/>. Accessed June 14, 2019.
14. Weller C. What you need to know about egg-freezing, the hot new perk at Google, Apple, and Facebook. *Business Insider*. <https://www.businessinsider.com/egg-freezing-at-facebook-apple-google-hot-new-perk-2017-9>. Accessed June 14, 2019.

#### **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: 006  
(JUN-21)

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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1 Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the  
2 patient's right to accept, modify, and refuse treatment<sup>1,2</sup>; and  
3

4 Whereas, A patient desiring treatment must provide informed consent which can only be given  
5 after being informed of their diagnosis, if known, the nature and purpose of any recommended  
6 interventions, and the anticipated risks, benefits, and consequences of all options<sup>3-5</sup>; and  
7

8 Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed  
9 consent as "a process of communication whereby a patient is enabled to make an informed and  
10 voluntary decision about accepting or declining medical care"<sup>6</sup>; and  
11

12 Whereas, A patient's provider is legally and ethically obligated to inform patients as part of the  
13 consent process any party who can be reasonably anticipated to be part in their care team  
14 including but not limited to residents, nurses, students, and allied health professionals<sup>3,7</sup>; and  
15

16 Whereas, Teaching hospitals historically used the generalized consent form as permission to  
17 perform exams of the genital areas, including for educational purposes, without deliberately  
18 informing patients of opportunities to limit how any care teams or their members could be  
19 involved in their care experience<sup>4,8-14</sup>; and  
20

21 Whereas, In the 1980s, women vocalized demands to be asked for additional explicit consent  
22 prior to undergoing educational pelvic exams in the operating room and indicated that doing so  
23 without this consent constituted physical assault<sup>15</sup>; and  
24

25 Whereas, Surveys conducted in 2003 in Philadelphia and 2005 in Oklahoma found medical  
26 students were still conducting educational pelvic and rectal exams on anesthetized or  
27 unconscious patients without having obtained prior consent to do so<sup>12,16,17</sup>; and  
28

29 Whereas, Educational pelvic exams were historically performed on patients under anesthesia in  
30 operating rooms without explicit patient consent, including by medical students not directly  
31 involved or not reasonably anticipating to be involved with the patient's ongoing care and when  
32 the patient's surgical indications did not warrant a pelvic exam<sup>18</sup>; and  
33

34 Whereas, Varying attitudes on educating medical students on invasive exams compounded with  
35 pressures on students to achieve high academic and clinical marks may contribute to erosion of  
36 consideration for scenarios when additional patient consent is indicated<sup>16,19-24</sup>; and

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

5 Whereas, Various states have passed legislation outlawing educational pelvic exams and/or  
6 pelvic exams in general, potentially even when indicated as part of a procedure, on a woman  
7 who is anesthetized or unconscious without prior consent to specifically do so<sup>14,25-32</sup>; and  
8

9 Whereas, The Joint Commission maintains that patients may decline participating in elements of  
10 clinical training programs, such as working with medical students<sup>12,33</sup>; and  
11

12 Whereas, The AMA Code of Medical Ethics states that patient "participation in medical  
13 education is to the mutual benefit of patients and the health care system; nonetheless, patients'  
14 (or surrogates') refusal of care by a trainee should be respected in keeping with ethics  
15 guidance."<sup>34</sup>; and  
16

17 Whereas, While patients are often open to learner involvement in their care, they may deem  
18 scrutiny of more private body parts, particularly when solely for educational purposes, to warrant  
19 specific consent beyond the level provided for general care and treatment<sup>15,35-37</sup>; and  
20

21 Whereas, Use of professional standardized patients who teach female pelvic, male  
22 genitourinary, and rectal exams have already demonstrated significant value in medical  
23 education and further highlight the unnecessary nature of educational genital exams performed  
24 without explicit patient consent<sup>38-40</sup>; therefore be it  
25

26 RESOLVED, That our American Medical Association oppose performing physical exams on  
27 patients under anesthesia or on unconscious patients that offer the patient no personal benefit  
28 and are performed solely for teaching purposes without prior informed consent to do so  
29 (Directive to Take Action); and be it further  
30

31 RESOLVED, That our AMA encourage institutions to align current practices with published  
32 guidelines, recommendations, and policies to ensure patients are educated on pelvic,  
33 genitourinary, and rectal exams that occur under anesthesia (Directive to Take Action); and be it  
34 further  
35

36 RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in  
37 educational physical exams (Directive to Take Action); and be it further  
38

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

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

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

This topic has once again made the news in the last year and is a thorn in the side of our profession. To ensure the continued trust in our profession by our patients and therefore by the public at large, the AMA needs to make a clear statement that unnecessary pelvic exams on sedated patients without their consent is not appropriate. We must not waste the good will and trust we have garnered from the public. This should not be controversial and is already supported by ACOG.

#### **References:**

1. Sedig L. What's the Role of Autonomy in Patient- and Family-Centered Care When Patients and Family Members Don't Agree? *AMA J ethics*. 2016;18(1):12-17. doi:10.1001/journalofethics.2016.18.1.ecas2-1601
2. McCormick T. Principles of Bioethics. University of Washington School of Medicine. <https://depts.washington.edu/bioethx/tools/princpl.html>. Published 2013. Accessed March 23, 2019.
3. American Medical Association. AMA Code of Medical Ethics: Chapter 2- Opinions on Consent, Communication, and Decision Making. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-2.pdf>.
4. Weiner S. What "informed consent" really means. AAMCNews. <https://news.aamc.org/patient-care/article/what-informed-consent-really-means/>. Published 2019. Accessed March 24, 2019.
5. Hall DE, Prochazka A V, Fink AS. Informed consent for clinical treatment. *CMAJ*. 2012;184(5):533-540. doi:10.1503/cmaj.112120
6. ACOG Committee on Ethics. ACOG Committee Opinion No. 439: Informed Consent. *Obstet Gynecol*. 2015;114(2, Part 1):401-408. doi:10.1097/AOG.0b013e3181b48f7f
7. Centers for Medicare and Medicaid Services. Regulations and Interpretive Guidelines for Hospitals. State Operations Manual. [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf). Published 2018. Accessed March 24, 2019.
8. University of California San Francisco. Admissions and Discharge. [https://www.ucsfhealth.org/your\\_stay/admissions\\_and\\_discharge/](https://www.ucsfhealth.org/your_stay/admissions_and_discharge/). Published 2019. Accessed March 24, 2019.
9. Mayo Clinic. Mayo Clinic Authorizations and Service Terms. <https://www.mayoclinic.org/documents/mc0072-53-pdf/doc-20078759>. Accessed March 24, 2019.
10. Northwestern Medicine. My Consent to Medical Care. <https://www.nm.org/-/media/Northwestern/Resources/patients-and-visitors/northwestern-medicine-universal-consent-form.pdf?la=en>. Accessed March 24, 2019.
11. Cohen DL, Kessel RW, McCullough LB, Apostolides AY, Heiderich KJ, Alden ER. Pelvic examinations by medical students. *Am J Obstet Gynecol*. 1989;161(4):1013-1014. <http://www.ncbi.nlm.nih.gov/pubmed/2801817>.
12. Goldstein A. Practice vs. Privacy on Pelvic Exams. The Washington Post. [https://www.washingtonpost.com/archive/politics/2003/05/10/practice-vs-privacy-on-pelvic-exams/4e9185c4-4b4c-4d6a-a132-b21b8471da58/?noredirect=on&utm\\_term=.40fa8c6aa3a4](https://www.washingtonpost.com/archive/politics/2003/05/10/practice-vs-privacy-on-pelvic-exams/4e9185c4-4b4c-4d6a-a132-b21b8471da58/?noredirect=on&utm_term=.40fa8c6aa3a4). Published 2003. Accessed March 28, 2019.
13. Warren A. Using the Unconscious to Train Medical Students Faces Scrutiny. The Wall Street Journal. <https://www.wsj.com/articles/SB104743137253942000>. Published 2003.
14. Dube N. *Non-Consensual Pelvic Exams*. Hartford; 2019. <https://cga.ct.gov/2019/rpt/pdf/2019-R-0054.pdf>.
15. Bibby J, Boyd N, Redman CW, Luesley DM. Consent for vaginal examination by students on anaesthetised patients. *Lancet (London, England)*. 1988;2(8620):1150. <http://www.ncbi.nlm.nih.gov/pubmed/2903370>.
16. Ubel PA, Jepson C, Silver-Isenstadt A. Don't ask, don't tell: A change in medical student attitudes after obstetrics/gynecology clerkships toward seeking consent for pelvic examinations on an anesthetized patient. *Am J Obstet Gynecol*. 2003;188(2):575-579. doi:10.1067/mob.2003.85
17. Schniederjan S, Donovan GK. Ethics versus education: pelvic exams on anesthetized women. *J Okla State Med Assoc*. 2005;98(8):386-388. <http://www.ncbi.nlm.nih.gov/pubmed/16206868>.
18. Friesen P. Educational pelvic exams on anesthetized women: Why consent matters. *Bioethics*. 2018;32(5):298-307. doi:10.1111/bioe.12441
19. Teunissen PW. An inconvenient discussion. *Med Educ*. 2018;52(11):1104-1106. doi:10.1111/medu.13689
20. Santhirakumaran S, Kalkat HS, Sonagara VJ. Pelvic floor examination performed by medical students: a model to obtain consent. *Adv Med Educ Pract*. 2018;Volume 10:7-10. doi:10.2147/amep.s180310
21. Carson-Stevens A, Davies MM, Jones R, Chik ADP, Robbé IJ, Fiander AN. Framing patient consent for student involvement in pelvic examination: A dual model of autonomy. *J Med Ethics*. 2013;39(11):676-680. doi:10.1136/medethics-2012-100809
22. Van Den Einden LCG, Te Kolste MGJ, Lagro-Janssen ALM, Dukel L. Medical students' perceptions of the physician's role in not allowing them to perform gynecological examinations. *Acad Med*. 2014;89(1):77-83. doi:10.1097/ACM.0000000000000055
23. Bhoopatkar H, Wearn A, Vnuk A. Medical students' experience of performing female pelvic examinations:

- Opportunities and barriers. *Aust N Z J Obstet Gynaecol*. 2017;57(5):514-519. doi:10.1111/ajo.12634
24. ACOG Committee on Ethics. Professional Responsibilities in Obstetric–Gynecologic Medical Education and Training. *Int J Gynaecol Obstet*. June 2017. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Professional-Responsibilities-in-Obstetric-Gynecologic-Medical-Education-and-Training?IsMobileSet=false>.
25. Oregon State Legislature. *ORS 676.360 Pelvic Examinations*.; 2011. <https://law.justia.com/codes/oregon/2011/vol15/676/676-360/>.
26. California State Legislature. *AB-663 Pelvic Examinations*.; 2003. [http://leginfo.ca.gov/faces/billHistoryClient.xhtml?bill\\_id=200320040AB663](http://leginfo.ca.gov/faces/billHistoryClient.xhtml?bill_id=200320040AB663).
27. Hawaii State Legislature. *453-18 Pelvic Examinations on Anesthetized or Unconscious Female Patients*.; 2013. [http://cca.hawaii.gov/pvl/files/2013/08/hrs\\_pvl\\_453.pdf](http://cca.hawaii.gov/pvl/files/2013/08/hrs_pvl_453.pdf).
28. Virginia State Legislature. *54.1-2959. Supervised Training Programs; Students Enrolled in Schools of Medicine or Chiropractic Schools Allowed to Engage in Certain Activities; Prohibition of Unauthorized Pelvic Exams*.; 1984. <https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2959/>.
29. Iowa State Legislature. *147.114 - Prior Informed Consent Relative to Pelvic Examinations — Patient under Anesthesia or Unconscious — Penalties*.; 2017. <https://www.legis.iowa.gov/docs/code/2019/147.114.pdf>.
30. McDay D, Coleman K. *S.B. 188 CONSENT FOR MEDICAL PROCEDURE AMENDMENTS*. Salt Lake City; 2019. <https://le.utah.gov/~2019/bills/static/SB0188.html>.
31. Feldman B. *S.B. 0909 Health Care Practitioners - Medical Examinations on Anesthetized or Unconscious Patients*. Annapolis; 2019. <http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=01&id=sb0909&tab=subject3&ys=2019RS>.
32. Eisenberg A. New bills would ban pelvic exams without consent. Politico. [https://www.politico.com/states/new-york/albany/story/2019/03/13/new-bills-would-ban-pelvic-exams-without-consent-910976?fbclid=IwAR1p-pL2GMts\\_vLBs5rocNievgyYu2NV-m-oSV-qLgNneZfZSi6DnnclloyM](https://www.politico.com/states/new-york/albany/story/2019/03/13/new-bills-would-ban-pelvic-exams-without-consent-910976?fbclid=IwAR1p-pL2GMts_vLBs5rocNievgyYu2NV-m-oSV-qLgNneZfZSi6DnnclloyM). Published 2019.
33. Cohen DL, Kessel RW, McCullough LB, Apostolides AY, Alden ER, Heiderich K. The ethical implications of medical student involvement in the care and assessment of patients in teaching hospitals--informed consent from patients for student involvement. Part I: A description of the origin and implementation of policies governing medical student involvement. *Res Med Educ*. 1985;24:138-145. <http://www.ncbi.nlm.nih.gov/pubmed/3854718>.
34. American Medical Association. *AMA Code of Medical Ethics: Chapter 1- Opinions on Patient-Physician Relationships*. <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-patient-physician-relationships>.
35. Ubel PA, Silver-Isenstadt A. Are patients willing to participate in medical education? *J Clin Ethics*. 2000;11(3):230-235. <http://www.ncbi.nlm.nih.gov/pubmed/11127637>.
36. Silver-Isenstadt A, Ubel PA. Erosion in medical students' attitudes about telling patients they are students. *J Gen Intern Med*. 1999;14(8):481-487. <http://www.ncbi.nlm.nih.gov/pubmed/10491232>.
37. Wainberg S, Wrigley H, Fair J, Ross S. Teaching Pelvic Examinations Under Anaesthesia: What Do Women Think? *J Obstet Gynaecol Canada*. 2010;32(1):49-53. doi:10.1016/S1701-2163(16)34404-8
38. Dumont T, Hakim J, Black A, Fleming N. Does an Advanced Pelvic Simulation Curriculum Improve Resident Performance on a Pediatric and Adolescent Gynecology Focused Objective Structured Clinical Examination? A Cohort Study. *J Pediatr Adolesc Gynecol*. 2016;29(3):276-279. doi:10.1016/j.jpag.2015.10.015
39. Nitsche JF, Shumard KM, Fino NF, et al. Effectiveness of Labor Cervical Examination Simulation in Medical Student Education. *Obstet Gynecol*. 2015;126 Suppl:13S-20S. doi:10.1097/AOG.0000000000001027
40. Wolfberg AJ. The patient as ally--learning the pelvic examination. *N Engl J Med*. 2007;356(9):889-890. doi:10.1056/NEJMp068016

## 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

### **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: 007  
(JUN-21)

Introduced by: Virginia, New Jersey, District of Columbia, Louisiana, American Association of Clinical Urologists, American Urological Association, Maryland

Subject: Nonconsensual Audio/Video Recording at Medical Encounters

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

Whereas, Physician malpractice defense attorneys and insurers are anticipating future litigation where patients have recorded telehealth visits without the physicians knowledge or consent; 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<sup>1</sup>; 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: 05/10/21

### AUTHOR'S STATEMENT OF PRIORITY

This resolution asks the AMA to develop policy on nonconsensual audio/video recordings during medical encounters. Studies already show this is occurring at significant rates and will likely increase with the expansion of telehealth during and post-pandemic. Additionally, malpractice defense attorneys are anticipating litigation where patients have recorded telehealth visits without the physician's consent or knowledge. The AMA should take a lead role in developing guidelines for both physicians and their patients on this subject.

### **References:**

<sup>1</sup> 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 patient's 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 patient's 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 film's 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: 008  
(JUN-21)

Introduced by: Pennsylvania

Subject: Organ Transplant Equity for Persons with Disabilities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, People with Intellectual and developmental disabilities (IDD) still face discrimination in  
2 access of care, specifically regarding barriers of access to transplant surgery, despite federal  
3 and local guidelines which protect against discrimination on the basis of disability; and  
4

5 Whereas, Transplant centers and medical professionals are unaware or noncompliant with  
6 clauses of the Americans with Disabilities Act, Rehabilitation Act, and Affordable Care Act  
7 prohibiting discrimination against people with disabilities as is applied to the organ transplant  
8 process; and  
9

10 Whereas, A 2004 survey found that only 52 percent of people with disabilities who requested a  
11 referral to a specialist regarding an organ transplant evaluation actually received a referral,  
12 while 35 percent of those “for whom a transplant had been suggested” never even received an  
13 evaluation; and  
14

15 Whereas, A 2008 survey of pediatric transplant centers found that 43 percent always or usually  
16 consider intellectual disabilities an absolute or relative contraindication to transplant due to  
17 assumptions and that in some cases, organ transplant centers may categorically refuse to  
18 evaluate a patient with a disability as a candidate for transplant; and  
19

20 Whereas, Throughout their medical education, Health, Oral Health, and Vision Health providers  
21 receive limited training on the special needs of people with IDD related to common problems  
22 and delivery of services, and patients report feeling that physicians generally have little  
23 understanding of living with a disability; and  
24

25 Whereas, If a person has a disability that is unrelated to the reason a person needs an organ  
26 transplant, the disability will generally have little or no impact on the likelihood of the transplant  
27 being successful and making assumptions regarding post-transplant quality of life for people  
28 with IDD violates AMA ethics; and  
29

30 Whereas, Congress established the need for an organization, the Organ Procurement and  
31 Transplant Network (OPTN), to facilitate the organ transplantation system across the many  
32 transplant centers and sources of organ donors in an efficient manner. The effective guidelines  
33 for organ allocation do not include disability status in non-discrimination section 5.4.A; and  
34

35 Whereas, Titles II and III of the Americans with Disabilities Act (ADA) prohibit discrimination  
36 against people with disabilities in all programs, activities and services of public entities and  
37 prohibit private places of public accommodation from discriminating against people with  
38 disabilities; and

1 Whereas, Section 504 of the Rehabilitation Act of 1973 prohibits federally funded programs  
2 including hospitals from denying qualified individuals the opportunity to participate in or benefit  
3 from federally funded programs, services, or other benefits, denying access to programs,  
4 services, benefits or opportunities to participate as a result of physical barriers, and denying  
5 employment opportunities they are otherwise entitled or qualified; and  
6

7 Whereas, Section 1557 of the Affordable Care Act prohibits discrimination on the basis of  
8 race, color, national origin, sex, age, or disability in certain health programs or activities and  
9 ensures physical access for individuals with disabilities to healthcare facilities and  
10 appropriate communication technology to assist persons who are visually or hearing  
11 impaired; therefore be it  
12

13 RESOLVED, That our American Medical Association support equitable inclusion of people with  
14 intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD  
15 Policy); and be it further  
16

17 RESOLVED, That our AMA support individuals with IDD having equal access to organ  
18 transplant services and protection from discrimination in rendering these services (New HOD  
19 Policy); and be it further  
20

21 RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation  
22 Network (OPTN) in adding disability status to their nondiscrimination policy under the National  
23 Organ Transplant Act of 1984 (New HOD Policy); and be it further  
24

25 RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination  
26 education materials for healthcare providers related to equitable inclusion of people with IDD in  
27 eligibility for transplant surgery. (Directive to Take Action)

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

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution recognizes that, although there are existing laws prohibiting discrimination on basis of disability, there is evidence to suggest that people with disabilities remain statistically less likely to receive consultation regarding -- and access to -- organ transplantation. Furthermore, although there is evidence to suggest that those with intellectual disabilities have similar outcomes after transplantation, there may be misperceptions to the contrary within the healthcare system. This resolution aims to have our AMA highlight this discrepancy between law and practice. We feel this is timely because this not only provides an avenue for our organization to advocate for those with disability, but to once again bring to the forefront the challenge of sufficient organ procurement in our nation.

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009  
(JUN-21)

Introduced by: Illinois

Subject: Supporting Women and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Racial bias within the healthcare system is a major factor in current healthcare disparities within the United States; and

Whereas, In recent years, there has been a stagnation of the percentage of women and minorities pursuing competitive fellowships within internal medicine; and

Whereas, In academic surgery, 19% are female, and women are less likely to be full professors when controlling for age as well as academic and clinical productivity; and

Whereas, Hispanic and African-American are more underrepresented in clinical academic medicine in current times than they were in 1990; and

Whereas, Women in academic surgery hold fewer positions of leadership on both the departmental and national level; and

Whereas, Chairs of academic surgery departments often rely heavily on internal hires and trusted networks instead of publicly posting positions, while simultaneously reporting difficulty in recruiting women and underrepresented minority applicants for those positions; therefore, be it

RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further

RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce  
Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further



1 RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national  
2 meeting attendance and maintain concrete and standing mechanisms for increasing  
3 participation for medical students within our AMA-MSS from medical schools with  
4 classically low national meeting attendance, which will be defined as less than five students  
5 per national AMA-MSS meeting over a period of five consecutive years, having one or  
6 more of the following characteristics:

1. Identify with group(s) underrepresented and disadvantaged in medicine
2. Are from medically underserved areas
3. Are first generation college graduates

as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action)

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

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely, urgent, and high priority. The link between bias – both implicit and overt – and healthcare disparities has been well documented. Ensuring that individuals who are typically underrepresented in the medical field have support and opportunities throughout their medical education and training to pursue a range of specialties and leadership positions is critical to helping promote equity across the healthcare spectrum.

#### References:

1. Mylavarapu P, Gupta NE, Gudi V, Mylavarapu A, Daniels LB, Patel M. Diversity Within the Most Competitive Internal Medicine Fellowships: Examining Trends from 2008 to 2018. *J Gen Intern Med.* 2020;35(9):2537-2544. doi:10.1007/s11606-020-06008-5.
2. Krebs ED, Narahari AK, Cook-Armstrong IO, Chandrabhatla AS, Mehaffey JH, Upchurch GR Jr, Showalter SL. The Changing Face of Academic Surgery: Overrepresentation of Women among Surgeon-Scientists with R01 Funding. *J Am Coll Surg.* 2020 Oct;231(4):427-433. doi: 10.1016/j.jamcollsurg.2020.06.013. Epub 2020 Jul 17. PMID: 32687880.
3. Lett LA, Orji WU, Sebro R. Declining racial and ethnic representation in clinical academic medicine: A longitudinal study of 16 US medical specialties. *PLoS One.* 2018 Nov 16;13(11):e0207274. doi: 10.1371/journal.pone.0207274. PMID: 30444928; PMCID: PMC6239326.
4. Shubeck SP, Newman EA, Vitous CA, Antunez AG, Dossett LA. Hiring Practices of US Academic Surgery Departments- Challenges and Opportunities for More Inclusive Hiring. *J Surg Res.* 2020 Oct;254:23-30. doi: 10.1016/j.jss.2020.03.054. Epub 2020 May 8. PMID: 32402833

#### RELEVANT AMA POLICY

##### **Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
  5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
  6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
  7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
  8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
  9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
  10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
  11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
  12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
  13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
  14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
- Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, 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.

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

#### **Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies

articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmation A-16

#### **Underrepresented Student Access to US Medical Schools H-350.960**

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

Citation: (Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

#### **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)

#### **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

**Minorities in the Health Professions H-350.978**

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.

(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.

(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.

(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.

(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.

(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010  
(JUN-21)

Introduced by: Georgia

Subject: Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, In many states, when a physician retires, has been suspended, or has their license is  
2 revoked, patients often have no warning that their physician's office is closed and no ability to  
3 obtain their medical records to transfer their care to another physician; and  
4

5 Whereas, Laws in many states provides that it is the physician who not only owns the patient's  
6 medical records, but also possesses the decision-making ability regarding sharing the records  
7 once a patient consents or signs a confidential waiver, except in cases of a subpoena or court  
8 order; and  
9

10 Whereas, Patients who are aware of their physician retiring are more likely to obtain their  
11 medical records upon request, than those patients who have had their physician suspended or  
12 revoked; and  
13

14 Whereas, The inability of patients to obtain their medical records could be detrimental for  
15 chronically ill patients who will need frequent follow-ups, creating increased hospitalizations with  
16 increased costs that may have been avoidable; and  
17

18 Whereas, There is no AMA policy clearly defining the suspended or revoked physician's  
19 responsibilities for patients with their medical records; and  
20

21 Whereas, For example, the Texas Medical Board has implemented a policy requiring a  
22 suspended or revoked Texas physician to appoint a board-approved custodian tasked with  
23 notifying patients within 30 days for the purpose of giving them their medical records; therefore  
24 be it  
25

26 RESOLVED, That the Council on Ethical and Judicial Affairs be requested to examine  
27 E-3.3.1, "Management of Medical Records," with regards to physicians whose license has been  
28 suspended or revoked and prepare a report to the 2021 Interim Meeting, including guidance for  
29 timely transfer of patient records to the patient or a state medical board-approved custodian.  
30 (Directive to Take Action)

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

Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

The mental and emotional toll of the COVID-19 pandemic has led to increases in substance use disorder that may lead to disciplinary action by medical boards across the country in the coming months. Many states currently have no system for ensuring that medical records are available to a patient where their physician's license has been suspended or revoked and the AMA has no current policy on what should happen to medical records in these instances. This harms these patients because it can lead to a delay in care or a need to repeat diagnostic exams or testing, which can increase costs. It is imperative that a solution is developed now so that ensures that patients can retrieve these records in order to find a new physician to continue their care and a delay in implementing this policy will negatively affect patients and public health in general. The AMA is most appropriate for advocating for this change given the lack of policy in states across the country.

**RELEVANT AMA POLICY****3.3.1 Management of Medical Records**

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patients' authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practices' medical records) should:

- (a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
- (b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
  - (i) immunization records, which should be kept indefinitely;
  - (ii) records of significant health events or conditions and interventions that could be expected to have a bearing on the patients' future health care needs, such as records of chemotherapy.
- (c) Make the medical record available:
  - (i) as requested or authorized by the patient (or the patients' authorized representative);
  - (ii) to the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death);
  - (iii) as otherwise required by law.
- (d) Never refuse to transfer the record on request by the patient or the patients' authorized representative, for any reason.
- (e) Charge a reasonable fee (if any) for the cost of transferring the record.
- (f) Appropriately store records not transferred to the patients' current physician.
- (g) Notify the patient about how to access the stored record and for how long the record will be available.
- (h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

**AMA Principles of Medical Ethics: IV,V**

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

Issued: 2016

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011  
(JUN-21)

Introduced by: Minority Affairs Section

Subject: Truth, Reconciliation, and Healing in Medicine and Medical Education

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Historical examination of AMA practices and policies have not always served to  
2 further equity and justice, but rather categorically exclude or severely limit opportunities for  
3 physicians based on race, ethnicity, gender, sexual orientation, capacity, and country of origin,  
4 and perpetuate intergenerational harm to historically marginalized and minoritized  
5 communities<sup>1-4</sup>; and  
6

7 Whereas, AMA archives chronicle decisions by leadership primarily rooted in racism and white  
8 supremacy, which have contributed to the systems of power and oppression that structured the  
9 realities of health inequities among women, LGBTQ+, Jewish, Black, Indigenous, Latinx, and  
10 Asian populations then, and which persist today<sup>5-14</sup>; and  
11

12 Whereas, The 1910 “Medical Education in the United States and Canada: A Report to the  
13 Carnegie Foundation for the Advancement of Teaching” (a.k.a. “The Flexner Report”)  
14 commissioned by the AMA’s Council on Medical Education recommended the closure of five out  
15 of the seven historically Black college or university (HBCU) affiliated medical schools existing at  
16 the time and described the role of Black physicians as sanitarians and hygienists to “protect”  
17 white people from “Black diseases”<sup>15,16</sup>; and  
18

19 Whereas, A recent study in *JAMA Network Open* found that the five HBCU-affiliated schools  
20 closed as a result of the Flexner Report’s recommendations would have produced an additional  
21 27,773 Black medical graduates in the years between their closure and 2019, increasing the  
22 number of Black medical graduates by 29% in 2019 alone<sup>17</sup>; and  
23

24 Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the  
25 areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice  
26 through the adoption and implementation of policies, processes, and programs that center  
27 equity and antiracism, such as the founding of the AMA Center for Health Equity, recognizing  
28 racism as a public health threat, characterizing race as a social construct, reconsidering the  
29 clinical application of race, and acknowledging the way communities are policed is a social  
30 determinant of health, among others<sup>18</sup>; and  
31

32 Whereas, In May 2021, the AMA Center for Health Equity released its three-year organizational  
33 strategic action plan to embed racial justice and advance health equity within the AMA and  
34 across medicine, including “fostering pathways for truth, racial healing, reconciliation and  
35 transformation for AMA’s past” through restorative justice<sup>19,20</sup>; therefore be it

- 1 RESOLVED, That our American Medical Association establish a combined external and internal  
2 task force to guide organizational transformation within and beyond the AMA toward restorative  
3 justice to promote truth, reconciliation, and healing in medicine and medical education.  
4 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY:**

As an extension of the AMA Center for Health Equity strategic action plan, this resolution calls for the creation of a task force to strengthen organizational capacity to advance and operationalize equity from within and across medicine through restorative justice. The task force will guide our AMA's transformational work, including historical identification of and accountability for past harmful policies, processes, and archival silence, to promote truth, reconciliation, and healing.

Establishing a task force of this nature is an actionable directive that expands upon and supports ongoing initiatives to dismantle structural racism while presenting an opportunity to evaluate the role of institutions in maintaining these structures.

**References:**

1. Baker RB. The American Medical Association and Race. *AMA Journal of Ethics*. 2014;16(6):479-488. doi:[10.1001/virtualmentor.2014.16.6.mhst1-1406](https://doi.org/10.1001/virtualmentor.2014.16.6.mhst1-1406)
2. Baker RB, Washington HA, Olakanmi O, et al. Creating a Segregated Medical Profession: African American Physicians and Organized Medicine, 1846-1910. *Journal of the National Medical Association*. 2009;101(6):501-512. doi:[10.1016/S0027-9684\(15\)30935-4](https://doi.org/10.1016/S0027-9684(15)30935-4)
3. Baker RB. The American Medical Association and Race. *AMA Journal of Ethics*. 2014;16(6):479-488. doi:[10.1001/virtualmentor.2014.16.6.mhst1-1406](https://doi.org/10.1001/virtualmentor.2014.16.6.mhst1-1406)
4. NATHAN SMITH DAVIS, M.D. *Journal of the American Medical Association*. 1904;XLII(26):1688-1688. doi:[10.1001/jama.1904.02490710020003](https://doi.org/10.1001/jama.1904.02490710020003)
5. AMA. Transactions of the American Medical Association. Published 1849. [http://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc\\_id](http://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id)
6. The Transactions of the American Medical Association v .0022 i .000 Pub . Date 1871
7. The Transactions of the American Medical Association v .0007 i .000 Pub . Date 1854
8. Sokoloff L. The rise and decline of the Jewish quota in medical school admissions. *Bull NY Acad Med*. 1992;68(4):497-518. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1808007/>
9. Rubin MH. Immigration, Quotas, And its Impact on Medical Education. Published online 2013. [https://wakespace.lib.wfu.edu/bitstream/handle/10339/38516/Rubin\\_wfu\\_0248M\\_10382.pdf](https://wakespace.lib.wfu.edu/bitstream/handle/10339/38516/Rubin_wfu_0248M_10382.pdf)
10. deShazo RD. The Racial Divide in American Medicine: Black Physicians and the Struggle for Justice in Health Care . University Press of Mississippi; 2018 .
11. House of Delegates Proceedings, Annual Convention v .1965 i .000 Pub . Date June 20, 1965
12. AMA. House of Delegates Proceedings, 120th Annual Convention .
13. AMA. House of Delegates Proceedings, 128th Annual Convention .
14. AMA House of Delegates Proceedings, 34th Interim Meeting. [https://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc\\_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama\\_arch%2FHOD00001%2F00000111&pg\\_seq=49](https://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000111&pg_seq=49)
15. Flexner A, Pritchett HS, Carnegie Foundation for the Advancement of Teaching. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. Vol no. 4. New York City: 1910.
16. Savitt T. Abraham Flexner and the black medical schools. 1992. *J Natl Med Assoc*. 2006 Sep;98(9):1415-24. PMID: 17019906; PMCID: PMC2569717.
17. Campbell, KM, Corral, I, Infante Linares, JL, Tumin, D. 2020. Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools. *JAMA Netw Open*. 3(8):e2015220.
18. Keeys M, Baca J, Maybank A. Race, Racism, and the Policy of 21st Century Medicine. *Yale J Biol Med*. 2021;94(1):153-157.
19. American Medical Association. AMA releases plan dedicated to embedding racial justice and advancing health equity. Published May 11, 2021. Accessed May 11, 2021. <https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing>
20. American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. Published May 11, 2021. Accessed May 11, 2021. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>



## **RELEVANT AMA POLICY**

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

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

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19

### **Improving Healthcare of Hispanic Populations in the United States H-350.975**

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.

(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.

(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.

(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.

(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.

(6) Promote research into effectiveness of Hispanic health education methods.

(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

### **Improving the Health of Black and Minority Populations H-350.972**

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Citation: (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)

### **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;

#### **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

#### **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 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

#### **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.

Citation: (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.

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

#### **Racism as a Public Health Threat H-65.952**

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes 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.
3. Our AMA will 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, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages 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.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

**Plan for Continued Progress Toward Health Equity D-180.981**

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.

2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18;

**AMA Support of American Indian Health Career Opportunities H-350.981**

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)

**Racial Essentialism in Medicine D-350.981**

1. Our AMA recognizes 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.

2. Our AMA encourages 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.

3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.

4. Our AMA will 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.

5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20;

**Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953**

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.

2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.

3. Our AMA encourages 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 that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends 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.

Citation: Res. 11, I-20

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmation A-16

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19;

#### **Diversity in the Physician Workforce and Access to Care D-200.982**

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

Citation: CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16;

#### **Health Plan Initiatives Addressing Social Determinants of Health H-165.822**

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20

#### **Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919**

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

**Alignment of Accreditation Across the Medical Education Continuum H-295.862**

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
  - a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
  - b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
  - c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
 All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
  - a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
  - b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

Citation: (CME Rep. 4, A-14; Appended: CME Rep. 10, A-15)

**Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917**

1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.

Citation: Res. 910, I-16; Appended: Res. 410, A-19



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012  
(JUN-21)

Introduced by: Young Physicians Section

Subject: Increasing Public Umbilical Cord Blood Donations in Transplant Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Allogeneic stem cell transplants continue to save lives, reaching over 20,000  
2 procedures per year in the United States<sup>1</sup>; and  
3

4 Whereas, Allogeneic stem cell therapy can only save lives in patients matched with a  
5 donor; and  
6

7 Whereas, Umbilical cord blood stem cells offer clinical advantages over traditional stem cell  
8 transplants in select scenarios<sup>2</sup>; and  
9

10 Whereas, Umbilical cord blood transplants increase the ethnic diversity of patients eligible for  
11 transplant<sup>3</sup>; and  
12

13 Whereas, The American Society for Transplantation and Cellular Therapy<sup>4</sup>, the American  
14 College of Obstetricians and Gynecologists<sup>5</sup>, and the American Academy of Pediatrics<sup>6</sup> all  
15 support public (altruistic) donation of cord blood when possible; and  
16

17 Whereas, Public donation of cord blood is difficult if the birthing hospital does not support public  
18 cord donation; and  
19

20 Whereas, Very few hospitals support in-house public cord blood donation infrastructure - only  
21 two hospitals in Ohio, and three each in New York and Massachusetts<sup>7</sup>; and  
22

23 Whereas, Many hospitals which provide comprehensive care including both childbirths and stem  
24 cell transplants are notably absent from these lists; therefore be it  
25

26 RESOLVED, That our American Medical Association encourage all hospitals with obstetrics  
27 programs to make available to patients and reduce barriers to public (altruistic) umbilical cord  
28 blood donation (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all  
31 states. (Directive to Take Action)

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

Received: 05/12/21

### AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for support for tying an option for public cord blood donation on Labor and Delivery to transplant programs quality metrics at the same hospital. Though this is important, this impacts a small number of physicians and is not a time-sensitive issue. Specialty organizations may also be suited to making this push for policy. Therefore, we feel this is a low priority resolution.

#### References:

1. Center for International Blood and Marrow Transplant Research, Health Resources & Services Administration, US Department of Health and Human Services. Transplant Activity Report Covering 2012-2016: Table 1. Total number of HCTs performed in the United States and reported to CIBMTR\* 2012-2016. 26 Feb 2018. Accessed at [https://bloodcell.transplant.hrsa.gov/research/transplant\\_data/transplant\\_activity\\_report/summary-total\\_tx\\_by\\_year.pdf](https://bloodcell.transplant.hrsa.gov/research/transplant_data/transplant_activity_report/summary-total_tx_by_year.pdf)
2. The Leukemia & Lymphoma Society. Cord Blood Stem Cell Transplantation. 2 Aug 2007. Available at [https://www.lls.org/sites/default/files/file\\_assets/cordbloodstemcelltransplantation.pdf](https://www.lls.org/sites/default/files/file_assets/cordbloodstemcelltransplantation.pdf).
3. Be the Match. Cord blood donation frequently asked questions. Accessed 22 Apr 2019. Available at <https://bethematch.org/support-the-cause/donate-cord-blood/cord-blood-faqs/>.
4. American Society for Blood and Marrow Transplantation. ASBMT POSITION STATEMENT Collection and Preservation of Cord Blood for Personal Use. Biology of Blood and Marrow Transplantation 14:364 (2008). Available at [https://higherlogicdownload.s3.amazonaws.com/ASBMT/43a1f41f-55cb-4c97-9e78-c03e867db505/UploadedImages/ASBMT\\_Cord\\_Blood\\_Position\\_Statement.pdf](https://higherlogicdownload.s3.amazonaws.com/ASBMT/43a1f41f-55cb-4c97-9e78-c03e867db505/UploadedImages/ASBMT_Cord_Blood_Position_Statement.pdf).
5. American College of Obstetricians and Gynecology. ACOG Committee Opinion Number 771. 21 Feb 2019. Available at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Genetics/Umbilical-Cord-Blood-Banking>.
6. Section on Hematology/Oncology and Section on Allergy/Immunology, American Academy of Pediatrics. Cord Blood Banking for Potential Future Transplantation. Pediatrics Jan 2007, 119 (1) 161-164; DOI: 10.1542/peds.2006-2900. Available at <https://pediatrics.aappublications.org/content/pediatrics/119/1/165.full.pdf>.
7. Be the Match. List of Participating Hospitals. Accessed 22 Apr 2019. Available at <https://bethematch.org/support-the-cause/donate-cord-blood/how-to-donate-cord-blood/participating-hospitals/>.

### **RELEVANT AMA POLICY**

#### Code of Medical Ethics. 6.1.5 Umbilical Cord Blood Banking

Transplants of umbilical cord blood have been recommended or performed to treat a variety of conditions. Cord blood is also a potential source of stem and progenitor cells with possible therapeutic applications. Nonetheless, collection and storage of cord blood raise ethical concerns with regard to patient safety, autonomy, and potential for conflict of interest. In addition, storage of umbilical cord blood in private as opposed to public banks can raise concerns about access to cord blood for transplantation.

Physicians who provide obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples.

Physicians who participate in collecting umbilical cord blood for storage should:

- (a) Ensure that collection procedures do not interfere with standard delivery practices or the safety of a newborn or the mother.
- (b) Obtain informed consent for the collection of umbilical cord blood stem cells before the onset of labor whenever feasible. Physicians should disclose their ties to cord blood banks, public or private, as part of the informed consent process.
- (c) Decline financial or other inducements for providing samples to cord blood banks.
- (d) Encourage women who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:
  - (i) in view of the cost of private banking and limited likelihood of use;
  - (ii) to help increase availability of stem cells for transplantation.
- (e) Discuss the option of private banking of umbilical cord blood when there is a family predisposition to a condition for which umbilical cord stem cells are therapeutically indicated.
- (f) Continue to monitor ongoing research into the safety and effectiveness of various methods of cord blood collection and use.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013  
(JUN-21)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine  
and Medical Professionalism

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as  
2 well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or  
3 the right to keep hair in an uncut or untrimmed manner <sup>1</sup>; and  
4

5 Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for  
6 cultural purposes and serves as a way to express values of a demographic group or particular  
7 society for religious, spiritual, or gender identification <sup>2</sup>; and  
8

9 Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for  
10 racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural  
11 headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious  
12 association <sup>3-6</sup>; and  
13

14 Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate  
15 against any individual based on an "... individual's race, color, religion, sex, or national origin",  
16 and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also  
17 unintentional discrimination on the enumerated proscribed ground <sup>7</sup>; and  
18

19 Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part  
20 of medical professionalism standards tend to be euro-centric and penalize those with non-euro-  
21 centric phenotypical features and/or culture <sup>8,9</sup>; and  
22

23 Whereas, In 2019, the State of California and New York City have passed laws to address hair  
24 discrimination within the workplace through the CROWN Act (SB 188) and the NYC  
25 Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the  
26 Basis of Hair <sup>1,3</sup>; and  
27

28 Whereas, United States Armed Forces have repealed several bans on natural hair and cultural  
29 headwear in the workplace (Army Regulation 670-1, Section 3-2) <sup>10</sup>; and  
30

31 Whereas, Qualitative analysis of minority resident physicians has revealed the additional  
32 challenges to embracing their racial identities in a professional setting results in less job  
33 satisfaction and more susceptibility to burnout <sup>11</sup>; and  
34

35 Whereas, Studies show "a positive association between physician-patient racial/ethnic  
36 concordance and patients' receiving preventive care, being satisfied with their care overall..." <sup>12</sup>;  
37 and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace (New HOD Policy).

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

Date Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to build upon recently adopted AMA policy on racism in medicine and promotion of health equity, both of which are major priorities.

Natural hair and cultural headwear can be a proxy for racial discrimination and therefore should be protected from discrimination tactics. It has been demonstrated through the establishment of policies and laws in California, New York City, and (most recently) Cincinnati that current discrimination policies do not adequately address this specific form of discrimination. This is an incredibly common issue experienced by many of our peers in the medical community, particularly minority women. This creates an unjust educational and professional environment, as repeat chemical or heat hair treatments are costly, time-consuming, and incredibly damaging to hair and skin. This practice impedes the collective advancement of minority women in medicine and healthcare. This timely resolution would address a critical gap in existing AMA policy. By the AMA stating explicitly that natural hair and cultural headwear is professional and accepted in the medical field, it will change the culture and attitude around this topic.

#### **References:**

1. Commission on Human Rights. *NYC Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the Basis of Hair*. New York City, NY; 2019.
2. Chico, B. Gender Headwear Traditions in Judaism and Islam. *Dress*. 2000; 27(1): 18-36.
3. State of California. Crown Act (Senate Bill No. 188). 2019; 58.
4. D. W. Greene. A Multidimensional Analysis of What Not to Wear in the Workplace: Hijabs and Natural Hair. *FIU L. Rev.* 2013; 333(8).
5. Barnhoorn PC, Youngson C. Refining a Definition of Medical Professionalism. *Academic Medicine*. 2014;89(12):1579.
6. Maddox, K. B. Perspectives on Racial Phenotypicality Bias. *Personality and Social Psych. Rev.* 2004;8(4): 383-401.
7. Congress of the United States of America. Civil Rights Act of 1964 (1964).
8. Yoshino K. *Covering: the Hidden Assault on Our Civil Rights*. New York, NY: Random House Trade Paperbacks; 2007.
9. Wynia MK, Papadakis MA, Sullivan WM, Hafferty FW. More Than a List of Values and Desired Behaviors. *Academic Medicine*. 2014;89(5):712-714.

10. Rhodan M. Military Rolls Back Restriction on Black Hairstyles. *Time*. <https://time.com/3107647/military-black-hairstyles/>. Published August 13, 2014. Accessed September 15, 2019.
11. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. *JAMA Network Open*. 2018;1(5).
12. Reede JY. A Recurring Theme: The Need For Minority Physicians. *Health Affairs*. 2003;22(4):91-93.

## **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. (BOT Rep. 27, A-19)

### **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)

### **Teacher-Learner Relationship In Medical Education H-295.955**

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions,

with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

#### CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher. In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unflinching honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98, Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07, Reaffirmed: CME Rep. 9, A-13)

#### **Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919**

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. (Res. 307, A-09, Appended: Res. 955, I-17)

**Eliminating Religious Discrimination from Residency Programs H-310.923**

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. (CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16)

**Discrimination Against Physicians by Patients D-65.991**

Our AMA will study: (1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests. (Res. 018, A-18)

**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)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014  
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural  
2 policies targeting minorities, especially the Black community,<sup>1-4</sup> including disproportionate rates  
3 of incarceration,<sup>5-7</sup> residential segregation,<sup>8</sup> and unfair labor and employment policies; and  
4

5 Whereas, Toxic stresses of racism<sup>9</sup>, incarceration, community violence, and low socioeconomic  
6 status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk  
7 behavior<sup>10</sup>, disease, and early death in minority children<sup>11,12</sup>; and  
8

9 Whereas, The racial wealth gap in the United States has increased dramatically, as households  
10 with black children hold just one cent for every dollar held by households with non-Hispanic  
11 white children as of 2016<sup>13,14</sup>; and  
12

13 Whereas, Income has been shown to be positively correlated with life expectancy, increased  
14 access to care, and improved health outcomes<sup>15,16</sup>; and  
15

16 Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to  
17 education and job opportunities,<sup>17,18</sup> which are correlated with positive health outcomes,<sup>19,20</sup> for  
18 the African American community; and  
19

20 Whereas, The United States has never created a commission to formally study the health,  
21 economic or social impacts of slavery and the Jim Crow era on African Americans and the  
22 resolution of those injustices through the context of reparations<sup>14,21</sup>; and  
23

24 Whereas, Reparations, encompassing a broad variety of public aid including but not limited to  
25 direct compensation, special education and job training, and community support for  
26 descendants of slaves, have been discussed as a means to support the marginalized Black  
27 community and end multi-generational poverty and its associated racial inequities<sup>21</sup>; and  
28

29 Whereas, In 2015, Chicago became the first city in the United States to propose reparations for  
30 victims of police torture and brutality, in a measure including \$5.5 million in direct compensation,  
31 free college education to survivors, a formal apology from the city, and education on police  
32 torture in public schools<sup>22</sup>; and  
33

34 Whereas, Reparations are designed to promote intergenerational wealth amongst affected  
35 communities, which in turn will increase the health outcomes of these communities<sup>14,23</sup>, and



Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989<sup>21</sup>; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes<sup>23–25</sup>; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over \$60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past<sup>26,27</sup>; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation<sup>28–30</sup>; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population<sup>14,30,31</sup>; and

Whereas, The black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly black medical schools after the 1910 publication of the Flexner Report<sup>31</sup>; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships<sup>32,33</sup>; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders<sup>33</sup>; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action)

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

Date Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

Our AMA made health equity and addressing racism in medicine some of its top priorities over the past year. This resolution builds upon this body of policy by asking our AMA to support the study of reparations as a means to reduce racial inequalities.

The historical exclusion of African American physicians into the AMA led to the Creation of the National Medical Association in 1895, and subsequently the Student National Medical Association in 1964. Their creation paved the way for African-American physicians and medical students to formally enter the realm of organized medicine, given that they were otherwise barred from joining previously established organizations such as the AMA. The NMA and SNMA allowed for organized support of addressing the needs of the underserved and to developing culturally competent and socially conscious physicians. Given the long historical context of this resolution, supported by the July 10th 2008 AMA apology that states in part "past history of racial inequality toward African-American physicians, and shares its current efforts to increase the ranks of minority physicians and their participation in the AMA" - The timing of this resolution is sound. We have a duty to study how reparations within the field of medicine would impact our Black patients and how we as an organization might participate in that reparative process to reduce racial health inequity.

**References:**

1. Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health*. 2019;40:105-125. doi:10.1146/annurev-publhealth-040218-043750
2. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet Lond Engl*. 2017;389(10077):1453-1463. doi:10.1016/S0140-6736(17)30569-X
3. Phojanakong P, Brown Weida E, Grimaldi G, Lê-Scherban F, Chilton M. Experiences of Racial and Ethnic Discrimination Are Associated with Food Insecurity and Poor Health. *Int J Environ Res Public Health*. 2019;16(22). doi:10.3390/ijerph16224369
4. Kerr J, Jackson T. Stigma, sexual risks, and the war on drugs: Examining drug policy and HIV/AIDS inequities among African Americans using the Drug War HIV/AIDS Inequities Model. *Int J Drug Policy*. 2016;37:31-41. doi:10.1016/j.drugpo.2016.07.007
5. Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public Health and the Epidemic of Incarceration. *Annu Rev Public Health*. 2012;33(1):325-339. doi:10.1146/annurev-publhealth-031811-124614
6. Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *Lancet Lond Engl*. 2017;389(10077):1464-1474. doi:10.1016/S0140-6736(17)30259-3
7. Barnert ES, Perry R, Morris RE. Juvenile Incarceration and Health. *Acad Pediatr*. 2016;16(2):99-109. doi:10.1016/j.acap.2015.09.004
8. Mehra R, Boyd LM, Ickovics JR. Racial residential segregation and adverse birth outcomes: A systematic review and meta-analysis. *Soc Sci Med* 1982. 2017;191:237-250. doi:10.1016/j.socscimed.2017.09.018
9. Beck, Andrew F., et al. "The color of health: how racism, segregation, and inequality affect the health and well-being of preterm infants and their families." *Pediatric research* (2019): 1-8. doi: 10.1038/s41390-019-0513-6
10. Duru, O. Kenrik, et al. "Allostatic load burden and racial disparities in mortality." *Journal of the National Medical Association* 104.1-2 (2012): 89-95. doi: 10.1016/S0027-9684(15)30120-6
11. Mersky, J. P., J. Topitzes, and Arthur J. Reynolds. "Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the US." *Child abuse & neglect* 37.11 (2013): 917-925. doi: 10.1016/j.chiabu.2013.07.011
12. Felitti, Vincent J., et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." *American journal of preventive medicine* 14.4 (1998): 245-258. doi: 10.1016/S0749-3797(98)00017-8
13. Percheski C, Gibson-Davis C. A Penny on the Dollar: Racial Inequalities in Wealth among Households with Children: *Socius*. Published online June 1, 2020. doi:10.1177/2378023120916616
14. Hannah-Jones N. From the Magazine: 'It Is Time for Reparations.' *The New York Times*. <https://www.nytimes.com/interactive/2020/06/24/magazine/reparations-slavery.html>. Published June 24, 2020. Accessed July 23, 2020.
15. Chetty R, Stepner M, Abraham S, et al. The Association Between Income and Life Expectancy in the United States, 2001-2014. *JAMA*. 2016;315(16):1750-1766. doi:10.1001/jama.2016.4226
16. Dubay LC, Lebrun LA. Health, Behavior, and Health Care Disparities: Disentangling the Effects of Income and Race in the United States: *Int J Health Serv*. Published online October 1, 2012. doi:10.2190/HS.42.4.c
17. Bleich SN, Findling MG, Casey LS, et al. Discrimination in the United States: Experiences of black Americans. *Health Serv Res*. 2019;54 Suppl 2:1399-1408. doi:10.1111/1475-6773.13220
18. Pager D, Shepherd H. The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets. *Annu Rev Sociol*. 2008;34:181-209. doi:10.1146/annurev.soc.33.040406.131740
19. Burke MP, Jones SJ, Frongillo EA, Fram MS, Blake CE, Freedman DA. Severity of household food insecurity and lifetime racial discrimination among African-American households in South Carolina. *Ethn Health*. 2018;23(3):276-292. doi:10.1080/13557858.2016.1263286

20. Alcalá HE, Cook DM. Racial Discrimination in Health Care and Utilization of Health Care: a Cross-sectional Study of California Adults. *J Gen Intern Med*. 2018;33(10):1760-1767. doi:10.1007/s11606-018-4614-4
21. Coates T-N. The Case for Reparations. *The Atlantic*. Accessed June 20, 2020. <https://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/>
22. History – Chicago Torture Justice Center. Accessed August 22, 2020. <https://chicagotorturejustice.org/about-us/history/>
23. Asheville, North Carolina, Approves Reparations for Black Residents - *The New York Times*. Accessed August 22, 2020. <https://www.nytimes.com/2020/07/16/us/reparations-asheville-nc.html>
24. Providence mayor signs order to pursue truth, reparations for Black, Indigenous people - *News* - providencejournal.com - Providence, RI. Accessed August 22, 2020. <https://www.providencejournal.com/news/20200716/providence-mayor-signs-order-to-pursue-truth-reparations-for-black-indigenous-people>
25. AB-3121 Task Force to Study and Develop Reparation Proposals for African Americans. California Legislative Information. Published August 20, 2020. Accessed August 22, 2020. [https://leginfo.ca.gov/faces/billHistoryClient.xhtml?bill\\_id=201920200AB3121](https://leginfo.ca.gov/faces/billHistoryClient.xhtml?bill_id=201920200AB3121)
26. Holocaust Survivors And Victims' Families Receive Millions In Reparations From France. *NPR.org*. Accessed August 24, 2020. <https://www.npr.org/2019/02/07/692376994/holocaust-survivors-and-victims-families-receive-millions-in-reparations-from-fr>
27. Ibhawoh B. What Canada and South Africa can teach the U.S. about slavery reparations. *The Conversation*. Accessed August 24, 2020. <http://theconversation.com/what-canada-and-south-africa-can-teach-the-u-s-about-slavery-reparations-120318>
28. United Nations General Assembly. Report of the Working Group of Experts on People of African Descent on its mission to the United States of America, A/HRC/33/61/Add.2. Published online August 18, 2016.
29. Statement to the media by the United Nations' Working Group of Experts on People of African Descent, on the conclusion of its official visit to USA, 19-29 January 2016. United Nations Human Rights Office of the High Commissioner. Published January 29, 2016. Accessed June 20, 2020. <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17000&LangID=E>
30. Guzman J. UN human rights chief urges reparations for "centuries of violence and discrimination" beginning with slavery and colonization. *TheHill*. Published June 18, 2020. Accessed August 27, 2020.
31. Hood RG. The "slave health deficit:" the case for reparations to bring health parity to African Americans. *J Natl Med Assoc*. 2001;93(1):1-5.
32. Baker RB. The American Medical Association and Race. *AMA J Ethics*. 2014;16(6):479-488. doi:10.1001/virtualmentor.2014.16.6.mhst1-1406.
33. Davis RM. Achieving Racial Harmony for the Benefit of Patients and Communities: Contrition, Reconciliation, and Collaboration. *JAMA*. 2008;300(3):323-325. doi:10.1001/jama.300.3.323

## RELEVANT AMA POLICY

### 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

### 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; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

### **Improving the Health of Black and Minority Populations H-350.972**

Our AMA supports: (1) A greater emphasis on **minority** access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of **Minority** Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. **minority** Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and **Minority** Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

### **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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015  
(JUN-21)

Introduced by: Medical Student Section  
GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Opposition to the Criminalization and Undue Restriction of Evidence-Based  
Gender-Affirming Care for Transgender and Gender-Diverse Individuals

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Gender affirmation refers to the process of recognizing one's gender identity through  
2 social, psychological, and legal methods and may include medical interventions such as  
3 pubertal suppression, hormone therapy, and surgery<sup>1</sup>; and  
4

5 Whereas, Gender-affirming healthcare refers to care that is sensitive, responsive, and affirming  
6 to transgender patients' gender identities and/or expressions<sup>1</sup>; and  
7

8 Whereas, Transgender and gender-diverse (TGD) youth are at greatly increased mental health  
9 risks: for example, more than 50% of female-to-male transgender adolescents reported an  
10 attempted suicide, compared to 14.1% among all adolescents<sup>2</sup>; and  
11

12 Whereas, TGD youth given gender-affirming treatment had lower lifetime odds of suicidal  
13 ideation as compared to those who desired but did not receive such treatment, decreasing rates  
14 of mental illness to those comparable to cisgender youth<sup>3-5</sup>; and  
15

16 Whereas, Even though it is currently legal for physicians to provide gender-affirming care for  
17 TGD youth and adults, these groups already face significant barriers to receiving this care<sup>6-7</sup>;  
18 and  
19

20 Whereas, The World Professional Association for Transgender Health (WPATH) and Endocrine  
21 Society suggest beginning medical pubertal suppression at Tanner Stage 2, which may even  
22 occur before the age of 10, and state that refusing timely gender-affirming care might prolong  
23 gender dysphoria<sup>8-9</sup>; and  
24

25 Whereas, In 2020, at least eight state legislatures, including Missouri, Florida, Illinois,  
26 Oklahoma, Colorado, South Carolina, Kentucky, and South Dakota, have introduced legislation  
27 that would criminally punish physicians who follow evidence-based practices for treating  
28 adolescents with gender dysphoria<sup>10</sup>; and  
29

30 Whereas, AMA policy H-65.965, Support of Human Rights and Freedom, opposes any  
31 discrimination based on an individual's sex, sexual orientation or gender identity<sup>11</sup>; and  
32

33 Whereas, In May 2019, six leading medical organizations - the American Academy of Family  
34 Physicians, American Academy of Pediatrics, American College of Obstetricians and  
35 Gynecologists, American College of Physicians, American Osteopathic Association, and  
36 American Psychiatric Association - issued a joint statement detailing opposition to "efforts in

1 state legislatures across the United States that inappropriately interfere with the patient-  
 2 physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in  
 3 some cases, even criminalize physicians who deliver safe, legal, and necessary medical care”<sup>12</sup>;  
 4 and

5  
 6 Whereas, Our AMA has spoken out on numerous occasions in opposition to state legislatures  
 7 attempting to undermine the patient-physician relationship either through criminalizing  
 8 healthcare decision-making or through censoring the content of physicians’ counseling on topics  
 9 like firearm safety or family planning options; and

10  
 11 Whereas, Our AMA has previously determined it prudent to specifically oppose the  
 12 criminalization of medical care to populations that have been politicized in state legislatures,  
 13 such as policy H-440.876, which supports the right of physicians to provide medical care to  
 14 undocumented immigrant patients without fear of retribution; and

15  
 16 Whereas, Our AMA policy D-160.999 “Opposition to Criminalizing Healthcare Decisions” seeks  
 17 to educate physicians regarding the continuing threat posed by the criminalization of healthcare  
 18 decision-making and the existence of our model legislation “An Act to Prohibit the  
 19 Criminalization of Healthcare Decision-Making”, and the timely introduction of this resolution in  
 20 the House of Delegates (HOD) further serves this purpose; therefore be it

21  
 22 RESOLVED, That our American Medical Association amend policy H-185.927, “Clarification of  
 23 Medical Necessity for Treatment of Gender Dysphoria,” by addition and deletion to read as  
 24 follows:

25  
 26 Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927  
 27 Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria,  
 28 as determined by shared decision making between the patient and physician, are  
 29 medically necessary as outlined by generally-accepted standards of medical and  
 30 surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to  
 31 provide medically necessary care for gender dysphoria; and (3) opposes the  
 32 criminalization and otherwise undue restriction of evidence-based gender-affirming  
 33 care. (Modify Current HOD Policy)

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

Date Received: 05/12/21

#### AUTHOR’S STATEMENT OF PRIORITY

The AMA has long advocated for our LGBTQ+ patients and colleagues. This resolution seeks to amend policy H-185.927 and direct the AMA to active oppose efforts blocking the delivery of safe, gender-affirming care by physicians. While we recognize the fantastic advocacy that AMA has already carried out to defend physician provision of gender-affirming care, this language empowers us to engage in state-specific advocacy driven by state medical associations, who may not have the existing resources or background to adequately advocate against these new bills. 2021 is unlikely to be the endpoint for these attacks, and this language demonstrates AMA's commitment to LGBTQ health equity in no uncertain terms.

**References:**

1. Reisner SL, Radix A, Deutsch MB. Integrated and Gender-Affirming Transgender Clinical Care and Research. *J Acquir Immune Defic Syndr*. 2016;72:S235-S242. doi:10.1097/QAI.0000000000001088
2. Toomey RB, Syvertsen AK, Shramko M. Transgender Adolescent Suicide Behavior. 2018;142(4):20174218. [www.aappublications.org/news](http://www.aappublications.org/news).
3. Olson KR, Durwood L, Demeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016;137(3). doi:10.1542/peds.2015-3223
4. Allen LR, Watson LB, Egan AM, Moser CN. Well-being and suicidality among transgender youth after gender-affirming hormones. *Clin Pract Pediatr Psychol*. 2019;7(3):302-311. doi:10.1037/cpp0000288
5. Turban JL, King D, Carswell J, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020; 145 (2). doi: <https://doi.org/10.1542/peds.2019-1725>
6. Gridley SJ, Crouch JM, Evans Y, et al. Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth. *J Adolesc Heal*. 2016;59(3):254-261. doi:10.1016/j.jadohealth.2016.03.017
7. Puckett JA, Cleary P, Rossman K, Mustanski B, Newcomb ME. Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals. *Sex Res Soc Policy*. 2018;15(1):48-59. doi:10.1007/s13178-017-0295-8
8. Coleman E, Bockting W, et. al. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 7th Version. Minneapolis, MN: World Professional Association for Transgender Health; 2012.
9. Hembree, Wylie C, et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society\* Clinical Practice Guideline." *The Journal of Clinical Endocrinology & Metabolism*, vol. 102, no. 11, 2017, pp. 3869–3903., doi:10.1210/je.2017-01658.
10. Burns, Katelyn. "Why Republicans Are Suddenly in a Rush to Regulate Every Trans Kid's Puberty." *Vox, Vox*, 29 Jan. 2020, [www.vox.com/identities/2020/1/29/21083505/transgender-kids-legislation-puberty-blockers](http://www.vox.com/identities/2020/1/29/21083505/transgender-kids-legislation-puberty-blockers).
11. AMA Issue Brief, 2019. *Health insurance coverage for gender-affirming care of transgender patients*. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>
12. Joint Statement from AAFP, AAP, ACOG, ACP, AOA, and APA. Frontline Physicians Call on Politicians to End Political Interference in the Delivery of Evidence Based Medicine. March 15, 2019. <https://www.aafp.org/media-center/releases-statements/all/2019/physicians-call-on-politicians-to-end-political-interference-in-the-delivery-of-evidence-based-medicine.html>

**RELEVANT AMA POLICY****Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991**

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



violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

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

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

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

### **Plan for Continued Progress Toward Health Equity H-180.944**

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

BOT Rep. 33, A-18

### **Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876**

1. Our AMA: (a) opposes any policies, regulations or legislation that would **criminalize** or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.

2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

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

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

Res. 402, A-12

### **Preventing Anti-Transgender Violence H-65.957**

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive

and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Res. 008, A-19

#### **Access to Basic Human Services for Transgender Individuals H-65.964**

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Res. 010, A-17

#### **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

#### **Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122, A-08; Modified: Res. 05, A-16

#### **Government Interference in Patient Counseling H-373.995**

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

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

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

Res. 05, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016  
(JUN-21)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and  
Detention Centers

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people  
2 who have been accused and/or convicted of a crime<sup>1</sup>; and  
3

4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,  
5 people awaiting trial or sentence, or young offenders for short periods of time<sup>2</sup>; and  
6

7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual  
8 confined to a cell for 22 to 24 hours per day, routinely used as a punishment for disciplinary  
9 violations in correctional facilities and detention centers<sup>3</sup>; and  
10

11 Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as  
12 not standing up for headcount or not returning a food tray<sup>3,4</sup>; and  
13

14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means  
15 of reprisal for reporting unsafe and unsanitary conditions<sup>5,6</sup>; and  
16

17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because  
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of  
19 infectious disease<sup>7</sup>; and  
20

21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory  
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary  
23 measure overseen by medical professionals who treat prisoners with compassion and provide  
24 prisoners resources to aid their recovery<sup>7</sup>; and  
25

26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around  
27 60,000 people, currently reside in some form of solitary confinement<sup>8</sup>; and  
28

29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average  
30 of \$75,000 per prisoner per year<sup>9</sup>; and  
31

32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are  
33 offered few or no educational, vocational, or rehabilitative programs<sup>10</sup>; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes<sup>11-13</sup>; and

Whereas, There is a strong association between solitary confinement and self harm, for instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions<sup>4,13,14</sup>; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders<sup>14</sup>; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality than those who do not<sup>15</sup>; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses<sup>16</sup>; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services<sup>12,13</sup>; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement<sup>17</sup>; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism<sup>14,18-20</sup>; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety<sup>19</sup>; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates<sup>20</sup>; and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement<sup>8</sup>; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women<sup>21</sup>; and

1 Whereas, The United Nations and The International Convention on the Rights of the Child prohibit  
2 the solitary confinement of anyone under the age of 18<sup>22,23</sup>; and

3  
4 Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum Rules  
5 for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the use of  
6 solitary confinement for prisoners with mental or physical disabilities when their conditions would  
7 be exacerbated by such measures<sup>23</sup>; and

8  
9 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than  
10 15 days, because it is “cruel, inhuman or degrading treatment or punishment”<sup>23</sup>; and

11  
12 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in  
13 exceptional cases as a last resort, for as short a time as possible and subject to independent  
14 review”<sup>23</sup>; and

15  
16 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical  
17 and psychological health issues, and should be considered cruel and unusual punishment and a  
18 human rights violation<sup>24</sup>; and

19  
20 Whereas, At least some United States correctional facilities have managed to reform and  
21 reduce their use of solitary confinement in order to better respect the dignity and human rights  
22 of inmates while still maintaining the safety of correctional officers and inmates in jails and  
23 prisons<sup>18</sup>; and

24  
25 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%  
26 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff  
27 violence<sup>18</sup>; and

28  
29 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement  
30 population, violent incidents also dropped by nearly 70%<sup>19</sup>; and

31  
32 Whereas, A 2015 study found that placing male inmates who were violent in solitary  
33 confinement did not effectively deter or alter the probability, timing, or development of future  
34 misconduct or violence<sup>25</sup>; and

35  
36 Whereas, Some correctional facilities have created special units to protect vulnerable groups  
37 together with similar access to privileges and programs available to the general population  
38 without using solitary confinement as a means of protection<sup>18</sup>; and

39  
40 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for  
41 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New  
42 York City<sup>26</sup>; and

43  
44 Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for  
45 disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:

**Reducing ~~Opposing~~ the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983**

Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length, ~~with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for a short a time as possible;~~ and (2) ~~while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities. (Modify Current HOD Policy)

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

Date Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

Our delegation prioritizes protections for marginalized and underserved populations, including the incarcerated. This resolution denounces the use of solitary confinement, which evidence has shown to threaten the physical and mental health of incarcerated and detained persons. This resolution explains that humane alternatives are available to ensure safety and prevent violence. Our delegation has worked to solicit review from advocacy and staff to ensure the issue is timely, addresses a gap in policy, and without substantial concerns on feasibility or actionability.

**References:**

1. Correctional Facilities. National Institute of Justice. <https://nij.ojp.gov/topics/corrections/correctional-facilities>. Published 2020. Accessed September 19, 2020.
2. Definition of Detention Center by Oxford Dictionary. [https://www.lexico.com/en/definition/detention\\_center](https://www.lexico.com/en/definition/detention_center). Published 2020. Accessed September 19, 2020.
3. Halvorsen A. Solitary Confinement Of Mentally Ill Prisoners: A National Overview & How The Ada Can Be Leveraged To Encourage Best Practices. [https://mylaw2.usc.edu/why/students/orgs/ilj/assets/docs/27-6-Solitary Confinement of Mentally Ill Prisoners - Ashley Halvorsen\\_original.pdf](https://mylaw2.usc.edu/why/students/orgs/ilj/assets/docs/27-6-Solitary%20Confinement%20of%20Mentally%20Ill%20Prisoners_-_Ashley_Halvorsen_original.pdf) Published February 27, 2020. Accessed August 27, 2020.
4. Cloud DH, Drucker E, Browne A, Parsons J. Public Health and Solitary Confinement in the United States. *Am J Public Health*. 2015;105(1):18-26. doi:10.2105/AJPH.2014.302205
5. Paul K. Ice detainees faced medical neglect and hysterectomies, whistleblower alleges. The Guardian. <https://www.theguardian.com/us-news/2020/sep/14/ice-detainees-hysterectomies-medical-neglect-irwin-georgia>. Published Sep 14, 2020. Accessed September 19, 2020.
6. Gallagher E. The other problem with ICE detention: Solitary confinement. The Washington Post. <https://www.washingtonpost.com/outlook/2019/08/28/other-problem-with-ice-detention-solitary-confinement/>. Published August 28, 2019. Accessed September 19, 2020.
7. Cloud, D.H., Ahalt, C., Augustine, D. et al. Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19. *J GEN INTERN MED* 35, 2738–2742 (2020). <https://doi.org/10.1007/s11606-020-05968-y>
8. J. Resnik, A. VanCleave, K. Bell, A. Harrington, G. Conyers, C. McCarthy, J. Tumas, A. Wang. Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell. The Liman Center for Public Interest Law at Yale Law School and The Association of State Correctional Administrators. [10.2139/ssrn.3264350](https://ssrn.com/abstract=3264350) <https://ssrn.com/abstract=3264350> Published October 2018. Accessed August 26, 2020.
9. Reiter K. The Social Cost of Solitary Confinement. Time. <https://time.com/4540112/the-social-cost-of-solitary-confinement/>. Published October 31, 2016. Accessed August 28, 2020.

10. Solitary Confinement. National Commission on Correctional Healthcare. <https://www.ncchc.org/solitary-confinement>. Published April 10, 2016. Accessed August 26, 2020.
11. Mumtaz F, Khan MI, Zubair M, Dehpour AR. Neurobiology and consequences of social isolation stress in animal model—a comprehensive review. *Biomedicine & Pharmacotherapy*. 2018;105:1205-1222. doi:10.1016/j.biopha.2018.05.086
12. Friedler B, Crapser J, McCullough L. One is the deadliest number: the detrimental effects of social isolation on cerebrovascular diseases and cognition. *Acta Neuropathologica*. 2015;129(4):493-509. doi:10.1007/s00401-014-1377-9
13. Hagan BO, et al. History of Solitary Confinement Is Associated with Post-Traumatic Stress Disorder Symptoms among Individuals Recently Released from Prison. *J Urban Health*. 2018;95(2):141-148.
14. Brinkley-Rubinstein L, et al. Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA*. 2019;2(10):e1912516. doi:10.1001/jamanetworkopen.2019.12516
15. Wildeman C, Andersen LH. Solitary confinement placement and post-release mortality risk among formerly incarcerated individuals: a population-based study [published correction appears in *Lancet Public Health*. 2020 Jul;5(7):e374]. *Lancet Public Health*. 2020;5(2):e107-e113. doi:10.1016/S2468-2667(19)30271-3
16. Beck A. Use of Restrictive Housing in U.S. Prisons and Jails, 2011–12. U.S. Department of Justice. <https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf>. Published October 2015. Accessed September 19, 2020.
17. Lowen M, Isaacs C, Williams B. Lifetime lockdown: How isolation conditions impact prisoner reentry. American Friends Service Committee. August 2012. [https://www.prisonpolicy.org/scans/afsc/lifetime\\_lockdown\\_report.pdf](https://www.prisonpolicy.org/scans/afsc/lifetime_lockdown_report.pdf). Accessed August 24, 2020.
18. Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives. VERA Institute of Justice. [https://www.vera.org/downloads/publications/solitary-confinement-misconceptions-safe-alternatives-report\\_1.pdf](https://www.vera.org/downloads/publications/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf). Published May 2015. Accessed September 19, 2020.
19. A solitary failure: The waste, cost, and harm of solitary confinement in Texas. American Civil Liberties Union of Texas, Texas Civil Rights Project Houston. <https://assets.documentcloud.org/documents/2096455/solitaryreport-2015-1.pdf>. Published February 2015. Accessed August 24, 2020.
20. Briefing Paper: The dangerous overuse of solitary confinement in the United States. American Civil Liberties Union. [https://www.aclu.org/sites/default/files/assets/stop\\_solitary\\_briefing\\_paper\\_updated\\_august\\_2014.pdf](https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf). Published August 2014. August 24, 2020.
21. Meyer IH, Flores AR, Stemple L, Romero AP, Wilson BD, Herman JL. Incarceration Rates and Traits of Sexual Minorities in the United States: National Inmate Survey, 2011-2012. *Am J Public Health*. 2017;107(2):267-273. doi:10.2105/AJPH.2016.303576
22. United Nations Rules for the Protection of Juveniles Deprived of their Liberty Adopted by General Assembly resolution 45/113 of 14 December 1990. The United Nations Human Rights Office of the High Commissioner. <https://www.ohchr.org/en/professionalinterest/pages/juvenilesdeprivedofliberty.aspx>. Published December 1990. Accessed September 20, 2020.
23. The United Nations Standard Minimum Rules for Treatment of Prisoners: The Nelson Mandela Rules. The United Nations Office on Drugs and Crime. [https://www.unodc.org/documents/justice-and-prison-reform/Nelson\\_Mandela\\_Rules-E-ebook.pdf](https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf). Published December 2015. Accessed September 20, 2020.
24. Coppola F. The brain in solitude: an (other) eighth amendment challenge to solitary confinement. *J Law Biosci*. 2019;6(1):184-225. Published 2019 Sep 25.
25. Morris, RG. Exploring the Effect of Exposure to Short-Term Solitary Confinement Among Violent Prison Inmates. *J Quant Criminol*. 2016;32:1–22. <https://doi.org/10.1007/s10940-015-9250-0>
26. Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, Venters H. From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. *Int J Environ Res Public Health*. 2016;13(2):182. Published 2016 Feb 2. doi:10.3390/ijerph13020182

## RELEVANT AMA POLICY

### Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Res. 412, A-18.

### Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.



**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.

**Human Rights and Health Professionals H-65.981**

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

**Human Rights H-65.997**

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

**Appropriate Placement of Transgender Prisoners H-430.982**

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

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

BOT Rep. 24, A-18.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017  
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Sex work entails the provision of sexual services for money or goods, while sex  
2 trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a  
3 person for the purpose of a commercial sex act<sup>34,35</sup>; and  
4

5 Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter,  
6 food, or money; survival sex is considered a subset of “sex work” since it does not involve the  
7 force, fraud, or explicit coercion defined in sex trafficking; and  
8

9 Whereas, Consent is defined by the federal government as a freely given agreement to the  
10 conduct at issue by a competent person, and consent is not constituted by lack of verbal or  
11 physical resistance; and  
12

13 Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—  
14 often problematically falls under the term “consensual” sex work; thus, consent in the realm of  
15 sex work falls on a spectrum, rather than a binary definition; and  
16

17 Whereas, Globally, the three major policy approaches to sex trade regulation are  
18 criminalization, full and partial decriminalization, and legalization; the US primarily utilizes  
19 criminalization; and  
20

21 Whereas, Criminalization of sex work is associated with higher prevalence of unsafe practices,  
22 such as not using condoms, higher rates of STIs, lower likelihood of seeking healthcare for  
23 illness or injury related to sex work, and greater likelihood of violence and rape of the individuals  
24 selling sex;<sup>13-18,20,23</sup>; and  
25

26 Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers  
27 were four times more likely to report mental health issues, possibly due to increased risks that  
28 come with illegal sex work such as assault and arrest<sup>16</sup>; and  
29

30 Whereas, Because sex work is criminalized in the United States, many sex workers struggle to  
31 obtain health insurance, leading to the majority being uninsured and paying out of pocket for  
32 healthcare<sup>18</sup>; and  
33

34 Whereas, A systematic review of the literature estimates that 15-20% of men in the United  
35 States have paid for sex at least once<sup>19</sup>; and

1 Whereas, In 2016, over 33,000 people, many of whom were parents, were arrested for  
2 prostitution and commercial vices in the United States, putting their children at an increased risk  
3 for depression, anxiety, antisocial behavior, drug use, and cognitive delays<sup>21,22</sup>; and  
4

5 Whereas, The threat of potential arrest forces sex workers to move their business into sparsely-  
6 populated and poorly-patrolled areas such as rural or industrial settings, where pimps and  
7 clients can perpetrate violence with impunity<sup>26</sup>; and  
8

9 Whereas, Criminalization of sex work is associated with higher rates of sexual harassment,  
10 rape, and violence perpetrated by police against people selling sex<sup>2,24,25,28</sup>; and  
11

12 Whereas, Individuals who sell sex for survival are often those from among the most vulnerable  
13 communities, such as undocumented immigrants, minority ethnic populations, the economically  
14 marginalized, homeless populations and especially homeless LGBTQ populations, and  
15 transgender people;<sup>28</sup>, and  
16

17 Whereas, In a nationwide study 12% of trans women reported earning income through sex  
18 work, with higher rates among trans women of color, and 77% of these women reported intimate  
19 partner violence, 72% reported sexual assault, and 86% reported police harassment; and  
20

21 Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work  
22 Projects, Amnesty International, and Human Rights Watch all recommend decriminalization of  
23 consensual sex work to improve access to health care for high risk populations, with the WHO  
24 specifying that decriminalization would help reduce HIV incidence<sup>1-3</sup>; and  
25

26 Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex,  
27 acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely-followed  
28 system of partial decriminalization and is employed in Sweden, Norway, Iceland, France,  
29 Ireland, Northern Ireland, Canada, and Israel<sup>36</sup>; and  
30

31 Whereas, In the Equality Model, people currently selling sex are offered voluntary participation  
32 in social services, and people found to be buying sex are offered voluntary participation  
33 programs to help them stop buying sex<sup>36</sup>; and  
34

35 Whereas, Partial decriminalization strategies such as the Equality Model are associated with a  
36 markedly lower rate of human trafficking, while full decriminalization and legalization are  
37 associated with increases in human trafficking to meet the increased demand for commercial  
38 sex, as well as increases in organized crime<sup>36,38,39</sup>; and  
39

40 Whereas, Transition from criminalization to the decriminalization of the sale of sex in the  
41 Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a  
42 comparatively lower number of persons trafficked compared to surrounding nations using other  
43 policy systems<sup>40</sup>; and  
44

45 Whereas, Though partial decriminalization will not eliminate all the risks of sex work, it will  
46 empower sex workers to self-organize and collaborate with law enforcement<sup>41</sup>; and  
47

48 Whereas, Among the various systems of prostitution policy, only the Equality Model has  
49 resulted in net decreases of human trafficking, violence against sex workers, and STI rates  
50 among the general population; therefore be it

1 RESOLVED, That our American Medical Association recognize the adverse health outcomes of  
2 criminalizing consensual sex work (New HOD Policy); and be it further

3  
4 RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex  
5 in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel  
6 keeping; and 3) support the expungement of criminal records of those previously convicted  
7 of sex work, including trafficking survivors (New HOD Policy); and be it further

8  
9 RESOLVED, That our AMA support research on the long-term health, including mental health,  
10 impacts of decriminalization of the sex trade. (New HOD Policy)

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

Date Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections for marginalized and underserved populations. This resolution asserts that sex work a widely misunderstood and neglected public health crisis that demands the attention of our AMA. It demonstrates the net positive public health benefits of decriminalizing sex work including stronger family units; safer work environments; decreased illegal sex tracking; improved access to healthcare by otherwise marginalized individuals; and fewer arrests of otherwise "normal," hard working citizens simply trying to live. These results have been demonstrated in United Kingdom, Australia, Belgium, Argentina, Denmark, Israel, the Netherlands, New Zealand, Spain, Switzerland, Singapore, and even in our own US state of Nevada. Clearly, sex work, in the same vein as drug use and abortion, has counterintuitive solutions that result in a better world for us all.

Our AMA has been leading the charge with evidence based solutions to many controversial issues in the past decades, and we believe that sex work is next. We urge this resolution's consideration and look forward to seeing the AMA join the WHO, UNFPA, UNAIDS, and many first world countries in destigmatizing what has long been a mislabeled immorality and improving the lives of many marginalized individuals.

#### **References:**

1. Amnesty International. Amnesty International Policy on State Obligations to Respect, Protect and Fulfill the Human Rights of Sex Workers.; 2016. <https://www.amnesty.org/en/documents/pol30/4062/2016/en/>. Accessed September 23, 2018.
2. Human Rights Watch. World Report 2014: Events Of 2013. USA: Human Rights Watch; 2014:41-53. [https://www.hrw.org/sites/default/files/wr2014\\_web\\_0.pdf](https://www.hrw.org/sites/default/files/wr2014_web_0.pdf). Accessed September 23, 2018.
3. Prüss-Ustün A, Wolf J, Driscoll T, Degenhardt L, Neira M, Calleja J. HIV Due to Female Sex Work: Regional and Global Estimates. *PLoS ONE*. 2013;8(5):e63476. doi:10.1371/journal.pone.0063476.
4. Policing and Crime Act of 2009, Parliament of the United Kingdom.
5. Van Meir J. Sex Work and the Politics of Space: Case Studies of Sex Workers in Argentina and Ecuador. *Social Sciences*. 2017;6(2):42. doi:10.3390/socsci6020042.
6. Prostitution. Government.nl. <https://www.government.nl/topics/prostitution>. Published 2018. Accessed September 2, 2018.
7. Prostitution Reform Act of 2003. Ministry of Justice, New Zealand.
8. Prostitution. Department of Security and Justice, Canton of Fribourg, Switzerland. [https://www.fr.ch/sites/default/files/contens/dsi/\\_www/files/pdf89/ang\\_faq\\_canton-fribourg\\_lprost\\_conseils-et-orientation1.pdf](https://www.fr.ch/sites/default/files/contens/dsi/_www/files/pdf89/ang_faq_canton-fribourg_lprost_conseils-et-orientation1.pdf). Published 2016. Accessed September 2, 2018.
9. Ja'afar L, Ho V, Lee M, Sherqueshaa S. CEDAW 68th Session Stakeholders Report By Sex Workers In Singapore.; 2017. [https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SGP/INT\\_CEDAW\\_NGO\\_SGP\\_29070\\_E.pdf](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SGP/INT_CEDAW_NGO_SGP_29070_E.pdf). Accessed September 2, 2018.
10. Nevada Revised Statute 201.354: Engaging in prostitution or solicitation for prostitution. <https://www.leg.state.nv.us/NRS/NRS-201.html#NRS201Sec354>.
11. Sullivan, B. (2010). When (Some) Prostitution is Legal: The Impact of Law Reform on Sex Work in Australia. *Journal of Law and Society*, [online] 37(1), pp.85-104. Available at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-6478.2010.00496.x> [Accessed 19 Apr. 2019].

12. All Women, All Rights, Sex Workers Included. Center for Health and Gender Equity. 2016. [http://www.genderhealth.org/files/uploads/All\\_Women\\_All\\_Rights\\_Sex\\_Workers\\_Included\\_Report.pdf](http://www.genderhealth.org/files/uploads/All_Women_All_Rights_Sex_Workers_Included_Report.pdf)
13. Kerrigan D, Kennedy CE, Morgan-Thomas R, et al. A community empowerment approach to the HIV response among sex workers: effectiveness, challenges, and considerations for implementation and scale-up. *Lancet* (London, England). 2015;385(9963):172-185. doi:10.1016/S0140-6736(14)60973-9.
14. Beyrer C, Crago A, Bekker L et al. An action agenda for HIV and sex workers. *The Lancet*. 2015;385(9964):287-301. doi:10.1016/S0140-6736(14)60933-8.
15. Shannon K, Strathdee S, Goldenberg S et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. *The Lancet*. 2015;385(9962):55-71. doi:10.1016/S0140-6736(14)60931-4.
16. Seib C, Fischer J, Najman J. The health of female sex workers from three industry sectors in Queensland, Australia. *Social Science & Medicine*. 2009;68(3):473-478. doi:10.1016/j.socscimed.2008.10.024.
17. Decker MR, Crago A-L, Chu SKH, et al. Human rights violations against sex workers: burden and effect on HIV. *Lancet* (London, England). 2015;385(9963):186-199. doi:10.1016/S0140-6736(14)60800-X.
18. Sunderland M. The Sex Workers Fighting for Better Health Care. *Broadly*. 2017. [https://broadly.vice.com/en\\_us/article/j5q9q4/the-sex-workers-fighting-for-better-health-care](https://broadly.vice.com/en_us/article/j5q9q4/the-sex-workers-fighting-for-better-health-care). Accessed September 2, 2018.
19. Shively M, Jalbert S, Kling R et al. Final Report On The Evaluation Of The First Offender Prostitution Program. Office of Research and Evaluation, National Institute of Justice, U.S. Department of Justice; 2008.
20. Cunningham S, Shah M. Decriminalizing Indoor Prostitution: Implications for Sexual Violence and Public Health. *Rev Econ Stud*. 2017;85(3):1683-1715. doi:10.1093/restud/rdx065.
21. Table 22: Arrests by State, 2016. FBI. <https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/tables/table-22>. Published 2018. Accessed September 2, 2018.
22. Davis L, Shlafer R. Mental health of adolescents with currently and formerly incarcerated parents. *J Adolesc*. 2017;54:120-134. doi:10.1016/j.adolescence.2016.10.006.
23. Raphael J, Reichert J, Powers M. Pimp Control and Violence: Domestic Sex Trafficking of Chicago Women and Girls. *Women Crim Justice*. 2010;20(1-2):89-104. doi:10.1080/08974451003641065.
24. Deering K, Amin A, Shoveller J et al. A Systematic Review of the Correlates of Violence Against Sex Workers. *Am J Public Health*. 2014;104(5):e42-e54.
25. Sex Workers Project at the Urban Justice Center (SWP) *Revolving Door: An Analysis of Street-Based Prostitution in New York City*. New York City, NY: Urban Justice Center; 2003:1-100. <http://sexworkersproject.org/downloads/RevolvingDoor.pdf>. Accessed September 2, 2018.
26. Shannon K. Violence, Condom Negotiation, and HIV/STI Risk Among Sex Workers. *JAMA*. 2010;304(5):573. doi:10.1001/jama.2010.1090.
27. World Health Organization. Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries. Recommendations for a public health approach. WHO [http://www.who.int/hiv/pub/guidelines/sex\\_worker/en/](http://www.who.int/hiv/pub/guidelines/sex_worker/en/). Accessed September 23, 2018.
28. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. Available at: <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf> [Accessed 19 Apr. 2019].
29. Farber H, Herbst D, Kuziemko I, Naidu S. Unions and Inequality Over the Twentieth Century: New Evidence from Survey Data. *Princeton Industrial Relations Section*. 2018. doi:10.3386/w24587.
30. Malinowski B, Minkler M, Stock L. Labor Unions: A Public Health Institution. *Am J Public Health*. 2015;105(2):261-271. doi:10.2105/ajph.2014.302309
31. Grant M. Organized Labor's Newest Heroes: Strippers. <https://www.theatlantic.com/sexes/archive/2012/11/organized-labors-newest-heroes-strippers/265376/>. Published 2018. Accessed September 2, 2018.
32. Jackson C, Heineman J. Repeal FOSTA and Decriminalize Sex Work. *SAGE journals*. 2018;17(3):74-75. doi:10.1177/1536504218792534.
33. Cunningham S, Kendall T. Risk behaviours among internet-facilitated sex workers: evidence from two new datasets. *Sex Transm Infect*. 2010;86(Suppl 3):iii100-iii105. doi:10.1136/sti.2010.044875.
34. Walls NE, Bell S. Correlates of Engaging in Survival Sex among Homeless Youth and Young Adults. *Journal of Sex Research*. 2011;48(5):423-436. doi:10.1080/00224499.2010.501916
35. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. Available at: <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>
36. Mathieson A, Branam E, Noble A. Prostitution Policy: Legalization, Decriminalization and the Nordic Model. *Seattle Journal for Social Justice*. 2016;14(2), article 10. Available at: <http://digitalcommons.law.seattleu.edu/sjsj/vol14/iss2/10>
37. Das P, Horton R. Bringing sex workers to the centre of the HIV response. *The Lancet*. 2014;385(9962):3-4. doi:10.1016/S0140-6736(14)61064-3
38. Cho S, Dreher A, Neumayer E. Does Legalized Prostitution Increase Human Trafficking? *World Development*. 2013; 41:67-82. <https://doi.org/10.1016/j.worlddev.2012.05.023>
39. Jakobsson N and Kotsadam A. *Eur J Law Econ*. 2013;35:87. <https://doi.org/10.1007/s10657-011-9232-0>
40. Unprotected: How Legalizing Prostitution Has Failed. Spiegel Online. <https://www.spiegel.de/international/germany/human-trafficking-persists-despite-legality-of-prostitution-in-germany-a-902533.html>. Published 2013.
41. Wurth MH, Schleifer R, McLemore M, Todrys KW, Amon JJ. Condoms as evidence of prostitution in the United States and the criminalization of sex work. *J Int AIDS Soc*. 2013;16(1):18626. doi:10.7448/IAS.16.1.18626

## RELEVANT AMA POLICY

### **Commercial Exploitation and Human Trafficking of Minors H-60.912**

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Res. 009, A-17

### **Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958**

Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and “best practices”. Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.

Res. 14, A-15; Modified: Res. 003, I-17

### **HIV/AIDS as a Global Public Health Priority H-20.922**

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of “treatment as prevention,” and the need for linkage of newly HIV-positive persons to clinical care and partner services.

CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

**Global HIV/AIDS Prevention H-20.898**

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.

Res. 439, A-08; Modified: Res. 003, I-17

**Physicians Response to Victims of Human Trafficking H-65.966**

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  - a. An assessment tool for health care professionals
  - b. Online training in recognizing and responding to human trafficking in a health care context
  - c. Speakers and materials for in-person training
  - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

BOT Rep. 20, A-13; Appended: Res. 313, A-15

**Human Trafficking / Slavery Awareness D-170.992**

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Res. 015, A-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018  
(JUN-21)

Introduced by: Medical Student Section

Subject: LGBTQ+ Representation in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, The Association of American Medical Colleges (AAMC) has defined  
2 underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are  
3 underrepresented in the medical profession relative to their numbers in the general population"  
4 since 2003, with an overarching goal to advocate for population parity<sup>1</sup>; and  
5

6 Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering  
7 diversity as referring solely to race and ethnicity is too narrow and that broadening the definition  
8 of diversity would help to encompass sexual orientation, religion, geography, disability, age,  
9 language, and gender identity<sup>2</sup>; and  
10

11 Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their  
12 sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as  
13 transgender; the last two components of the acronym can stand for queer or questioning and  
14 are meant to encompass all identities that are not heterosexual or cisgender<sup>3</sup>; and  
15

16 Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation,  
17 gender identity, or both of these identity aspects<sup>3-5</sup>; and  
18

19 Whereas, The National Institutes of Health (NIH) formally designated sexual and gender  
20 minorities (SGMs) as a health disparity population for NIH research due to mounting evidence  
21 that SGM populations have less access to healthcare and higher burdens of diseases such as  
22 depression, cancer, and HIV/AIDS<sup>6</sup>; and  
23

24 Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of  
25 heterosexual healthcare providers reported moderate to strong implicit preference for  
26 heterosexual patients over homosexual patients, while gay and lesbian providers showed more  
27 implicit preference in favor of homosexual patients<sup>7</sup>; and  
28

29 Whereas, In 2015, the American College of Physicians emphasized the need for "programs that  
30 would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer  
31 support to LGBT medical students, residents, and practicing physicians"<sup>8</sup>; and  
32

33 Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+  
34 people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth  
35 have experienced social ostracism because of their LGBTQ+ identity<sup>9</sup>; and



Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable<sup>10-12</sup>; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"<sup>13</sup>; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

Fiscal note: Moderate - between \$5,000 - \$10,000

Date received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

Evidenced-based advocacy and support for our LGBTQ+ colleagues have been cornerstones in the AMA's operations and initiatives. This resolution highlights the paucity and lack of comprehensive, repeated data representing LGBTQ+ demographic data both in the general population and in medicine. It further asserts that our AMA should advocate for initiatives that intentionally recruit and reaffirm our LGBTQ+ colleagues from the start of their training in medicine. Our delegation therefore urges the consideration of this resolution by the HOD for proper discussion and review of all stakeholders within our organization.

#### **References:**

1. (2017) "Underrepresented in Medicine Definition." Association of American Medical Colleges.
2. Castillo-Page, L. Diversity in Medical Education: Facts & Figures 2016. Association of American Medical Colleges. 2016.
3. The Williams Institute on the Study of Sexual Orientation and Gender Identity. Comment On The Definition Of Sexual Orientation And Gender Identity Submitted To The Drafting Committee, Yogyakarta Principles On The Application Of International Human Rights Law To Sexual Orientation And Gender Identity; 2017. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Yogyakarta-Review-SOGI-Definition.pdf>. Accessed September 25, 2019.
4. American Psychological Association. Gender Identity. In: APA Dictionary Of Psychology. 2nd ed. Washington, D.C.: Author; 2015:450,970,974.
5. Young RK. Sex/gender. In: AMA Manual of Style: A Guide for Authors and Editors. New York, NY: Oxford University Press; 2007. <https://www.amamanualofstyle.com/view/10.1093/jama/9780195176339.001.0001/med-9780195176339-div2-350>. Accessed September 18, 2019.
6. (2017) "Director's Message." National Institutes of Health: National Institute on Minority Health and Health Disparities.

7. Sabin *et al.* Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *American Journal of Public Health*. 2015 Sep;105(9):1831-1841.
8. Daniel, H. & Butkus, R. Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians. *Annals of Internal Medicine*. 2015 Jul;163(2):135-137
9. Sitkin, N. & Pachankia, J. Specialty Choice Among Sexual and Gender Minorities in Medicine: The Role of Specialty Prestige, Perceived Inclusion, and Medical School Climate. *LGBT Health*: 2016 Dec;3(6):451-460
10. Medical School Graduation Questionnaire. Association of American Medical Colleges; 2018:44.  
<https://www.aamc.org/download/490454/data/2018gqallschoolsummaryreport.pdf>. Accessed September 18, 2019.
11. Medical School Year Two Questionnaire. Association of American Medical Colleges; 2019:20.  
<https://www.aamc.org/download/496618/data/y2q2018report.pdf>. Accessed September 18, 2019
12. Matriculating Student Questionnaire. Association of American Medical Colleges; 2018:26.  
<https://www.aamc.org/download/494044/data/msq2018report.pdf>. Accessed September 18, 2019
13. Castillo-Page L. Diversity In Medical Education: Facts & Figures 2016. Association of American Medical Colleges; 2016.  
<http://www.aamcdiversityfactsandfigures2016.org/>. Accessed September 18, 2019.

## RELEVANT AMA POLICY:

**Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322** – Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. Res. 313, A-09 Modified: CME Rep. 6, A-11

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951** - Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06

Reaffirmed: CME Rep. 7, A- 08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16

**Medical Staff Development Plans H-225.961** – All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria

related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of .patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. 2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98)

**Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878** – Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019  
(JUN-21)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Race is a self-identified social construct that results in differential treatment of groups  
2 that leads to social inequity on people's health<sup>1,2</sup>; and  
3

4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-  
5 identification of their origin or descent, "roots," heritage, or place where the individual or their  
6 parents or ancestors were born<sup>3</sup>; and  
7

8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);  
9 and  
10

11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as  
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and  
13 Chicano/a/x" have been used interchangeably with race in case report<sup>4-7</sup>; and  
14

15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of  
16 origin and cultural heritage, constructs which can change over time<sup>8,9</sup>; and  
17

18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based  
19 consensus is necessary for optimal use of self-identified race as well as geographical  
20 ancestry<sup>10</sup>; and  
21

22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can  
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine<sup>11</sup>;  
24 and  
25

26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated  
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast  
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency  
29 department<sup>12</sup>; and  
30

31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in  
32 2015, there was substantial variation between states in administrative data misclassification of  
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native  
34 beneficiaries<sup>13</sup>; and  
35

36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the  
37 62 studies provided complete descriptions of their study populations<sup>14</sup>; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity<sup>15</sup>; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results<sup>16</sup>; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients<sup>16</sup>; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology<sup>16-18</sup>; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women<sup>4</sup>; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women<sup>19</sup>; and

Whereas, It was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences<sup>4</sup>; and

Whereas, Our AMA Board of Trustees on June 7<sup>th</sup>, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care<sup>20</sup>; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, 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” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias<sup>21</sup>; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity. (New HOD Policy)

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

Date Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

The current momentum with respect to the discussion of race and ethnicity necessitates a foundation on the definition, and our AMA witnessed this first hand from the incident with the JAMA podcast. Our AMA has already established policy discerning that race and ethnicity are conceptually distinct. Therefore, it is in the jurisdiction of our AMA to support scientific data that correctly aligns with the related but distinct nature of these words. The resolved clauses of this resolution are supported by H-350.974, specifically "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."

#### **References:**

1. Roberts D. *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*. New York, NY: The New Press; 2011.
2. Witzig R. The medicalization of race: scientific legitimization of a flawed social construct. *Ann Intern Med*. 1996;125(8):675-679. doi:10.7326/0003-4819-125-8-199610150-00008
3. Ethnic Origin or Race. Census. <https://www.census.gov/glossary/>. Accessed August 27, 2020.
4. Matoba N, Collins JW. Racial disparity in infant mortality. *Seminars in Perinatology*. 2017;41(6):354-359. doi:10.1053/j.semperi.2017.07.003
5. Pareek M, Bangash MN, Pareek N, et al. Ethnicity and COVID-19: an urgent public health research priority. *Lancet*. 2020;395(10234):1421-1422. doi:10.1016/S0140-6736(20)30922-3
6. Pan D, Sze Shirley, Minhas JS, et al. The impact of ethnicity on clinical outcomes in COVID-19: A systematic review. *Lancet*. 2020;(100404). doi: [10.1016/j.eclinm.2020.100404](https://doi.org/10.1016/j.eclinm.2020.100404)
7. Kim L, Whitaker M, O'Halloran A, et al. Hospitalization Rates and Characteristics of Children Aged <18 Years Hospitalized with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1–July 25, 2020. *MMWR Morb Mortal Wkly Rep*. ePub: 7 August 2020. DOI: [http://dx.doi.org/10.15585/mmwr.mm6932e3external icon](http://dx.doi.org/10.15585/mmwr.mm6932e3external%20icon).
8. Anderson MR, Moscou S, Fulchon C, Neuspiel DR. The Role of Race in the Clinical Presentation. *Fam Med* 2001;33(6):430-434
9. Liebler C, Rastogi S, Fernandez L, Noon J, Ennis SR. Americas Churning Races: Race and Ethnic Response Changes between Census 2000 and the 2010 Census. 2017. doi:10.31235/osf.io/d837h
10. Zhang F, Finkelstein J. Inconsistency in race and ethnic classification in pharmacogenetics studies and its potential clinical implications. *Pharmgenomics Pers Med*. 2019;12:107-123. Published 2019 Jul 2. doi:10.2147/PGPM.S207449
11. Miller, R. Black, gay, female: Multiple identities affect health outcomes. American Medical Association. Accessed September 20, 2020. <https://www.ama-assn.org/delivering-care/population-care/black-gay-female-multiple-ide>
12. Wechkunanukul K, Grantham H, Damarell R, Clark RA. The association between ethnicity and delay in seeking medical care for chest pain. *JBI Database of Systematic Reviews and Implementation Reports*. 2016;14(7):208-235. doi:10.1112/jbisrir-2016-003012
13. Grafova IB, Jarrín OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity [published online ahead of print, 2020 Jul 7]. *Med Care Res Rev*. 2020;1077558720935733. doi:10.1177/1077558720935733
14. Craven MR, Kia L, O'Dwyer LC, Stern E, Taft TH, Keefer L. Systematic review: methodological flaws in racial/ethnic reporting for gastroesophageal reflux disease. *Dis Esophagus*. 2018;31(3):dox154. doi:10.1093/dote/dox154
15. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*. 2020;383(9):874-882. doi:10.1056/nejmms2004740
16. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*. 2020;383(9):874-882. doi:10.1056/nejmms2004740
17. Bonham VL, Green ED, Pérez-Stable EJ. Examining How Race, Ethnicity, and Ancestry Data Are Used in Biomedical Research. *Jama*. 2018;320(15):1533. doi:10.1001/jama.2018.13609
18. Hernandez N, Song Y, Noble V, Eisner B. Pd47-10 Predicting Ureteral Stones In Emergency Department Patients With Flank Pain: An External Validation Of The Stone Score. *Journal of Urology*. 2016;195(4S). doi:10.1016/j.juro.2016.02.2698
19. El-Sayed AM, Paczkowski M, Rutherford CG, Keyes KM, Galea S. Social Environments, Genetics, and Black-White Disparities in Infant Mortality. *Paediatr Perinat Epidemiol*. 2015;29(6):546-551. doi:10.1111/ppe.12227
20. AMA Board of Trustees pledges action against racism, police brutality. <https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality>. Published June 7, 2020. Accessed August 27, 2020.
21. Page MJ, McKenzie JE, Higgins JPT. Tools for assessing risk of reporting biases in studies and syntheses of studies: a systematic review. *BMJ Open*. 2018;8(3):e019703. Published 2018 Mar 14. doi:10.1136/bmjopen-2017-019703

## **RELEVANT AMA POLICY**

### **Code of Medical Ethics 7.1.5 – Misconduct in Research**

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
  - (b) Resolve charges expeditiously.
  - (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
  - (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
  - (e) Maintain accurate and thorough documentation throughout the process.
  - (f) Maintain the highest degree of confidentiality.
  - (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.
- Issued: 2016

### **Code of Medical Ethics Opinion 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 identity, 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.

Issued: 2016

#### **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.

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 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

**Improving the Health of Black and Minority Populations, H-350.972:**

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

**Reducing Racial and Ethnic Disparities in Health Care, D-350.995:**

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

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

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

**Strategies for Eliminating Minority Health Care Disparities, D-350.996:**

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020  
(JUN-21)

Introduced by: Medical Student Section

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers,  
H-420.954

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC)  
2 or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to  
3 dissuade women from seeking legal abortion to terminate pregnancy<sup>1</sup>; and  
4

5 Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive  
6 medical facilities with licensed clinical professionals despite offering only select services,  
7 providing misinformation regarding abortion and contraception, and being largely staffed by  
8 volunteers instead of licensed care providers<sup>2,3</sup>; and  
9

10 Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable  
11 populations like minority and low-income women, which are the target population pursued by  
12 Pregnancy Counseling Centers<sup>4</sup>; and  
13

14 Whereas, Our AMA submitted an amicus brief to the U.S. Supreme Court in the case titled  
15 *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, in support of  
16 California's 2016 Reproductive Freedom, Accountability, Comprehensive Care and  
17 Transparency (FACT) Act on the basis of "medical ethics and a patient's right to informed  
18 consent"; and  
19

20 Whereas, California's FACT Act would have required all licensed medical facilities to publicly  
21 post information about affordable abortion and contraception services offered on their premises  
22 and required all unlicensed CPCs to disclose that they were not licensed medical clinics<sup>5-7</sup>; and  
23

24 Whereas, The public health repercussions that these entities pose by influencing women's  
25 reproductive health decisions is well established by putting women at greater risk when they are  
26 interrupted from seeking abortions in a timely manner, therefore subjecting them to the  
27 increased risk associated with late term abortions or unsafe abortions<sup>8</sup>; and  
28

29 Whereas, Pregnancy Counseling Centers perpetuate decreased prenatal care, substance  
30 abuse, preterm births, and increased incidence of negative physical and mental outcomes of  
31 babies that are born to women with unintended pregnancies<sup>8</sup>; and  
32

33 Whereas, Our AMA recognizes the unethical practices utilized by Pregnancy Counseling  
34 Centers in the Journal of Medical Ethics, such as providing misleading and false information that  
35 falls outside of medical standards<sup>9</sup>; and  
36

37 Whereas, These practices can cause women to miss abortion law cutoffs, receive dangerous  
38 late-stage abortions, and obstruct general access to abortion, all of which violate the ethical  
39 standards of beneficence, respect for autonomy, nonmaleficence, and justice<sup>9</sup>; and

1 Whereas, Pregnancy Counseling Centers often use federal funds from programs like Temporary  
2 Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title  
3 X family planning funding programs to fund their clinic's services despite only offering a limited,  
4 and often incomplete, number of services<sup>10, 11</sup>; and  
5

6 Whereas, Pregnancy Counseling Centers can be funded by anti-choice organizations despite  
7 not disclosing this connection, such as profits made by "Choose Life" license plates which fund  
8 Pregnancy Counseling Centers in 32 states<sup>12</sup>; and  
9

10 Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as  
11 of 2015, \$60 million in federal abstinence and marriage promotion funds have gone to  
12 Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling  
13 Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to  
14 Pregnancy Counseling Centers<sup>13, 14</sup>; and  
15

16 Whereas, A survey of 254 websites that identify individual Pregnancy Counseling Centers  
17 revealed only 85 contained information on male condoms or sexually transmitted infections  
18 (STIs), and of these 85, 63.5% discouraged condom use by providing negative facts about  
19 condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or  
20 videos of youth on their homepage to target younger populations<sup>15</sup>; and  
21

22 Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on  
23 search engine results, billboards, and buses near abortion clinics with abortion-related terms  
24 while hiding their agenda to dissuade women from seeking legal abortions<sup>16</sup>; and  
25

26 Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful  
27 tactics to dissuade women from seeking legal abortion such as wearing white coats although  
28 they hold no medical training, failing to disclose they are not a medical facility, expressing  
29 judgement to clients about their decisions to pursue abortion or contraception, offering  
30 ultrasound services for purpose of using fetal images to dissuade women from abortion, and  
31 providing false information on the links between abortion and adverse mental health sequelae,  
32 breast cancer, and future infertility<sup>16, 17</sup>; and  
33

34 Whereas, Pregnancy Counseling Centers do not charge for services and are often not licensed  
35 medical practices, therefore they are not held to the same state consumer protection statutes  
36 and consumer protection regulations that medical practices must abide by<sup>9</sup>; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-420.954, "Truth and  
2 Transparency in Pregnancy Counseling Centers," by insertion and deletion to read as follows, to  
3 further strengthen our AMA policy against the dissemination of purposely incomplete or  
4 deceptive information intended to mislead patients and the utilization of state and federal funds  
5 for potentially biased services provided by Pregnancy Counseling Centers:  
6

7 **Truth and Transparency in Pregnancy Counseling Centers H-420.954**

8 1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services  
9 disclose information on site, in its advertising; and before any services are provided  
10 concerning medical services, contraception, termination of pregnancy or referral for such  
11 services, adoption options or referral for such services that it does and does not provide,  
12 as well as fully disclose any financial, political, or religious associations which such  
13 entities may have;  
14

15 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical,  
16 emotional, or financial means) by any agency offering crisis pregnancy services that aim  
17 to discourage or interfere with a pregnant woman's pursuit of any medical services for  
18 the care of her unplanned pregnancy;  
19

20 3. Our AMA advocates that any entity providing medical or health services to pregnant  
21 women that markets medical or any clinical services abide by licensing requirements  
22 and have the appropriate qualified licensed personnel to do so and abide by federal  
23 health information privacy laws, and additionally disclose their level of compliance to  
24 such requirements and laws to patients receiving services;  
25

26 4. Our AMA opposes the utilization of state and federal funding to finance such entities  
27 offering crisis pregnancy services, which do not provide statistically validated evidence-  
28 based medical information and care to pregnant women. (Modify Current HOD Policy)

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

Date Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

We feel that this resolution addresses important gaps in AMA policy surrounding crisis pregnancy centers, which can act as a public health threat to pregnant individuals nationwide by disseminating misleading medical information and violating reproductive rights. These centers endanger the health of pregnant women nationwide, who have a right to know the political and religious associations of the institutions from which they are receiving counseling services.

There are numerous policies set significant precedent such as, H-5.993 which affirms that early termination of pregnancy is a medical matter between the patient and physician thus there should be no external factors interfering. Our AMA supports the disclosure of information regarding services provided from any entity offering crisis pregnancy services. Further, it advocates that entities providing medical or health services abide by licensing requirements. However, given the current state of many pregnancy counseling centers and their deceitful tactics, a stronger rewording of current AMA policy is justifiable. Current AMA policy does not require crisis pregnancy centers to disclose their financial, political, or religious associations, leaving a gap for dubious practices to flourish. Further, these practices have been found to dissuade or sometimes coerce women seeking abortions by taking the image of a doctor (white coat) to steer a woman's choice away from abortion on a non-medical basis. The trust by our patients is us as physicians of the upmost importance and our image is part of this trust.

**References:**

1. Family Research Council. A passion to serve: how pregnancy resource centers empower women, help families, and strengthen communities. 2nd ed. [downloads.frc.org/EF/EF12A47.pdf](https://downloads.frc.org/EF/EF12A47.pdf). Published 2010. Accessed August 25, 2019
2. Bryant AG, Levi EE. Abortion misinformation from crisis pregnancy centers in North Carolina. *Contraception*. 2012;86(6):752-756. doi:10.1016/j.contraception.2012.06.001.
3. Swartzendruber A, Steiner RJ, Newton-Levinson A. Contraceptive information on pregnancy resource center websites: a statewide content analysis. *Contraception*. 2018;98(2):158-162. doi:10.1016/j.contraception.2018.04.002.
4. Crisis Pregnancy Centers Undermine the Reproductive Health of Women of Color. NWLC. <https://nwlc.org/blog/crisis-pregnancy-centers-undermine-reproductive-health-women-color/>. Published March 28, 2013. Accessed August 26, 2019.
5. Borrero S, Frietsche S, Dehlendorf C. Crisis Pregnancy Centers: Faith Centers Operating in Bad Faith. *Journal of General Internal Medicine*. 2018;34(1):144-145. doi:10.1007/s11606-018-4703-4.
6. California Assembly Bill No. 775. Reproductive FACT Act. Published October 09, 2015. Accessed Sept 20, 2019. [https://leginfo.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160AB775](https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB775)
7. Crisis Pregnancy Centers: An Affront to Choice. [http://prochoice.org/pubs\\_research/publications/downloads/public\\_policy/cpc\\_report.pdf](http://prochoice.org/pubs_research/publications/downloads/public_policy/cpc_report.pdf). Published 2006. Accessed August 25, 2019.
8. Rosen JD. The Public Health Risks of Crisis Pregnancy Centers. *Perspectives on Sexual and Reproductive Health*. 2012;44(3):201-205. doi:10.1363/4420112.
9. Bryant AG, Swartz JJ. Why Crisis Pregnancy Centers Are Legal but Unethical. *Journal of Ethics | American Medical Association*. <https://journalofethics.ama-assn.org/article/why-crisis-pregnancy-centers-are-legal-unethical/2018-03>. Published March 1, 2018. Accessed August 25, 2019.
10. Henderson G. Anti-Choice Clinics Are Changing the Way They Operate to Qualify for Government Funding. *Vice*. [https://www.vice.com/en\\_us/article/8xpw8b/crisis-pregnancy-centers-medical-services-government-funding](https://www.vice.com/en_us/article/8xpw8b/crisis-pregnancy-centers-medical-services-government-funding). Published January 15, 2019. Accessed September 17, 2019.
11. Bryant AG, Narasimhan S, Bryant-Comstock K, Levi EE. Crisis pregnancy center websites: Information, misinformation and disinformation. *Contraception*. 2014;90(6):601-605. doi:10.1016/j.contraception.2014.07.003.
12. 'Choose Life' License Plates. Guttmacher Institute. <https://www.guttmacher.org/state-policy/explore/choose-life-license-plates>. Published August 1, 2019. Accessed August 25, 2019.
13. Robeznieks A. No easy calls in high court case on crisis pregnancy centers. *Patient Support & Advocacy*. <https://www.ama-assn.org/delivering-care/patient-support-advocacy/no-easy-calls-high-court-case-crisis-pregnancy-centers>. Published July 11, 2018. Accessed August 25, 2019.
14. *Crisis Pregnancies Center Lie: The Insidious Threat to Reproductive Freedom*. NARAL; 2015. <https://www.prochoiceamerica.org/wp-content/uploads/2017/04/cpc-report-2015.pdf>. Accessed September 17, 2019.
15. Bryant-Comstock K, Bryant AG, Narasimhan S, Levi EE. Information about Sexual Health on Crisis Pregnancy Center Web Sites: Accurate for Adolescents? *Journal of Pediatric and Adolescent Gynecology*. 2016;29(1):22-25. doi:10.1016/j.jpog.2015.05.008.
16. Report: Crisis Pregnancy Center Ads Misleading Women. *Truth In Advertising*. <https://www.truthinadvertising.org/report-crisis-pregnancy-center-ads-misleading-women/>. Published October 15, 2015. Accessed August 25, 2019.
17. Tsevat D, Miracle J, Gallo M. Evaluation of services at crisis pregnancy centers in Ohio. *Contraception*. 2016;94(4):391-392. doi:10.1016/j.contraception.2016.07.037.

## **RELEVANT AMA POLICY**

### **Truth and Transparency in Pregnancy Counseling Centers H-420.954**

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

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

Res. 7, I-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021  
(JUN-21)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The World Health Organization has unequivocally defined infertility as a disease state and cause of disability<sup>1</sup>; and

Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for transgender men, which can suppress ovulation, and estrogen therapy for transgender women, which can lead to impaired spermatogenesis and testicular atrophy<sup>2,3</sup>; and

Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and oophorectomy, which results in permanent sterility<sup>2,3</sup>; and

Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of respondents had received GAHT and 25% had undergone some form of GAS<sup>4</sup>; and

Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Society for Reproductive Medicine (ASRM) all recommend that transgender individuals receive counseling regarding potential loss of fertility and future reproductive options before initiating GAHT or undergoing GAS<sup>5-7</sup>; and

Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care Act created protections barring insurance discrimination based on sexual orientation and gender identity, although the current Administration has declined to defend this regulation and has been deferential to states<sup>8-10</sup>; and

Whereas, Employers and states that have implemented coverage of transition-related services have demonstrated minimal or no costs with vast immaterial/societal benefits<sup>10,11</sup>; and

Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of economic benefit, it is still difficult for transgender patients to obtain insurance coverage for gender-affirming care, fertility counseling, and gamete preservation<sup>3,4,12</sup>; and

Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with specific requirements determined on a state-by-state basis<sup>12,13</sup>; and

Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around qualifying diagnoses is variable between states<sup>12,13</sup>; and

Whereas, “Iatrogenic infertility” has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes<sup>12</sup>; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient’s physician (H-185.950)<sup>7,14</sup>; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is “caused directly or indirectly by necessary medical treatments as determined by a licensed physician” (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.990 by addition as follows:

#### **Infertility and Fertility Preservation Insurance Coverage H-185.990**

It is the policy of the AMA that (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; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950 by addition to read as follows:

#### **Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

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

Date Received: 05/12/21



#### AUTHOR'S STATEMENT OF PRIORITY

Gender-affirming therapy, including hormone therapy and surgery, is important to improving the mental health of patients experiencing gender dysphoria. It is therefore a necessary medical treatment and any resulting complications should be considered iatrogenic. Our AMA supports payment for iatrogenic infertility. However, patients who undergo gender affirming therapy and have the complication of iatrogenic infertility are often denied coverage for fertility therapy. Our delegation believes this resolution is a critical step to correcting this problem.

#### References:

1. [World Health Organization. Infertility definitions and terminology. WHO.   
http://www.who.int/reproductivehealth/topics/infertility/definitions/en/. Accessed March 29, 2020.](http://www.who.int/reproductivehealth/topics/infertility/definitions/en/)
2. Cheng PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM. Fertility concerns of the transgender patient. *Transl Androl Urol*. 2019;8(3):209-218. doi:10.21037/tau.2019.05.09
3. Mitu K. Transgender Reproductive Choice and Fertility Preservation. *AMA J Ethics*. 2016;18(11):1119-1125. doi:10.1001/journalofethics.2016.18.11.pfor2-1611.
4. [James SE, Herman JL, Rankin, S., Keisling M, Mottet L, Anafi M. \*The Report of the 2015 U.S. Transgender Survey\*. Washington, DC: National Center for Transgender Equality; 2016.   
https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. Accessed March 29, 2020.](https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf)
5. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903. doi:10.1210/je.2017-01658
6. Ethics Committee of the American Society for Reproductive Medicine. Access to fertility services by transgender persons: an Ethics Committee opinion. *Fertil Steril*. 2015;104(5):1111-1115. doi:10.1016/j.fertnstert.2015.08.021
7. Coleman E, Bockting W, Botzer M, et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *Int J Transgenderism*. 2012;13(4):165-232. doi:10.1080/15532739.2011.700873
8. [Office for Civil Rights \(OCR\). Laws and Regulations Enforced by OCR. HHS.gov.   
https://www.hhs.gov/civil-rights/providers/laws-regulations-guidance/laws/index.html. Published August 22, 2007. Accessed March 29, 2020.](https://www.hhs.gov/civil-rights/providers/laws-regulations-guidance/laws/index.html)
9. [American Medical Association. \*Issue Brief: Health Insurance Coverage for Gender-Affirming Care of Transgender Patients\*.: 2019;5.   
https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf. Accessed March 29, 2020.](https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf)
10. Baker KE. The Future of Transgender Coverage. *N Engl J Med*. 2017;376(19):1801-1804. doi:10.1056/NEJMp1702427
11. Padula WV, Heru S, Campbell JD. Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. *J Gen Intern Med*. 2016;31(4):394-401. doi:10.1007/s11606-015-3529-6
12. Kyweluk MA, Reinecke J, Chen D. Fertility Preservation Legislation in the United States: Potential Implications for Transgender Individuals. *LGBT Health*. 2019;6(7):331-334. doi:10.1089/lgbt.2019.0017
13. [Discover Infertility Treatment Coverage by U.S. State. RESOLVE: The National Infertility Association.   
https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/. Published 2020. Accessed March 29, 2020.](https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/)
14. [GLMA: Health Professionals Advancing LGBTQ Equality. 127-18-101: Transgender Healthcare. GLMA: Health Professionals Advancing LGBTQ Equality.   
https://transcendlegal.org/glma-health-professionals-advancing-lgbtq-equality. Published 2018. Accessed March 29, 2020.](https://transcendlegal.org/glma-health-professionals-advancing-lgbtq-equality)

#### RELEVANT AMA POLICY

##### **Right for Gamete Preservation Therapies H-65.956**

It is the policy of the AMA that (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; and (2) Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Res. 005, A-19

##### **Infertility and Fertility Preservation Insurance Coverage H-185.990**

It is the policy of the AMA that (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.

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

### **Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980**

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

### **Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122 A-08; Modified: Res. 05, A-16

### **Infertility Benefits for Veterans H-510.984**

The AMA (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; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

CMS Rep. 01, I-16; Appended: Res. 513, A-19

### **Storage & Use of Human Embryos- Ethics 4.2.5**

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:

(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.

- (b) Made available to other patients for purposes of reproduction.
- (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
- (d) Allowed to thaw and deteriorate.
- (e) Otherwise disposed of.

Under no circumstances should physicians participate in the sale of stored embryos.

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#### **Assisted Reproductive Technology- Ethics 4.2.1**

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. “Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

AMA Principles of Medical Ethics: I, V, VII

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