OPINIONS OF THE COUNCIL ON COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinions were presented by Monique A. Spillman, MD, Chair:

1. AMENDMENT TO OPINION 1.2.2, "DISRUPTIVE BEHAVIOR AND DISCRIMINATION BY PATIENTS"

CEJA Opinion. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1, November 2020, "Amendment to Opinion 1.2.2, 'Disruptive Behavior and Discrimination by Patients.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.2 – Disruptive Behavior and Discrimination by Patients'

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

Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

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

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those who are targeted.

(b) Always treat patients with compassion and respect.

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

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

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

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

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

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

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

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

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

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

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

2. AMENDMENT TO OPINION 8.7, "ROUTINE UNIVERSAL IMMUNIZATION OF PHYSICIANS"

CEJA Opinion. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2, November 2020, "Amendment to Opinion 8.7, 'Routine Universal Immunization of Physicians.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.7 – Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients.

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

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

REPORTS OF THE COUNCIL ON COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Monique A. Spillman, MD, Chair:

1. CEJA'S SUNSET REVIEW OF 2011 HOUSE POLICIES

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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

RECOMMENDATION

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

APPENDIX - Recommended Actions

Policy Number	Title	Text	Recommendation
D-140.980	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	Rescind; still relevant but superseded by more recent policy: H-140.898 Medical Profession Opposition to Physician Participation in

		not require physician participation. (Res. 9, A-01; Reaffirmed: CEJA Rep. 8, A-11)	Execution; 9.7.3 Capital Punishment Code of Medical Ethics; D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols; H-140.963 Secrecy and Physician Participation in State Executions
D-315.988	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 (2) ~~assume a leadership position in both developing a~~ Support continued updating of 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~~, 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~~. (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 here). Language amended as shown to reflect continued support of guidance.
D-350.991	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: H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice; D-350.981 Racial Essentialism in Medicine; H-65.952 Racism as a Public Health Threat; H-350.974 Racial and Ethnic Disparities in Health Care
D-435.995	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	Retain; remains relevant.

		groups, and mailing lists. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-120.991	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 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)	Retain; remains relevant
H-140.850	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.
H-140.901	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.
H-140.964	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.

H-140.967	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 ethics. (CEJA Rep. G, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-245.969	Opposing Legal Prohibition of Circumcision	Our AMA will oppose any attempt to legally prohibit male infant circumcision. (Res. 222, I-11)	Rescind; more recent policy better captures the nuances of supporting male infant circumcision: H-60.945 Neonatal Male Circumcision, which reads: 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. 2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.
H-275.976	Boundaries of Practice for Health Professionals	~~(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	Retain in part. Retain (1); remains relevant. Rescind (2); superseded by more recent policy H-300.982 Maintaining

		have a responsibility for maintaining coordination and continuity of their own health care. ~~(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)	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 standards should be reviewed and revised periodically.
H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	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: **Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community** 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	Retain; remains relevant.

		directly or indirectly, based on Physician's exercise of his/her rights under this paragraph. (Res. 8, A-11)	
H-350.972	Improving the Health of Black and Minority Populations	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)	Retain; remains relevant.
H-375.984	Participation in Peer Review	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.
H-375.989	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 H-375.962 Legal Protections for Peer Review, particularly: **Privilege.** 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. **Confidentiality.** Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.
H-375.993	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)	Rescind; superseded by more recent and encompassing policy H-375.962 Legal Protections for Peer Review, particularly: **Composition of the Peer Review Committee** 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.
H-375.997	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. (2) Medical peer review should be a local process. (3) Physicians should be ultimately responsible for all peer review of medical care. (4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the	Retain; remains relevant.

		medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review. (5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care. (6) Any system of medical peer review should have established procedures. (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. (8) Peer review should be an educational process for physicians to assure quality medical services. (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)	
H-405.978	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: 8.7 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." H-440.831 Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization has similar language regarding practice adjustments.
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	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	Retain; remains relevant.

		personnel to do so and abide by federal health information privacy laws. (Res. 7, I-11)	
H-440.946	Health Care Workers and HBV - Nonresponders to HBV Vaccine	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; (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; (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 (4) health care workers be encouraged to maintain HBV immunity by obtaining appropriate booster immunization when indicated. BOT Rep. X, I-91Reaffirmed: Sunset Report, I-01Reaffirmed: CEJA Rep. 8, A-11	Rescind; purpose and intent covered in H-405.978 Physicians with Communicable Diseases.
H-440.949	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 H-405.978 Physicians with Communicable Diseases.
H-460.906	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.
H-460.924	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;	Retain.

		(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)	
H-460.954	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.
H-460.972	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.
H-5.988	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 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)	Retain; remains relevant.

H-520.987	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.
H-525.987	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)	Rescind; superseded by more recent policy as outlined below: In re: infants and children with differences of sex development, see 2.2.1 Pediatric Decision Making, 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." In re: female genital mutilation, see H-525.980 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: 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 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.
H-65.978	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.
H-80.995	~~Evaluation of the Use of~~ DNA ~~Identification~~ Testing in Criminal Proceedings	~~(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 populations amongst which matches might be sought.~~ ~~(2) The independent validation of each probe used for DNA identification testing should be conducted.~~ ~~(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.~~ ~~(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)	Rescind (1), (2) and (3); these have been accomplished by the Organization of Scientific Area Committees for Forensic Science who develop national forensic science standards and have published (2020) quality control guidelines that address degradation and DNA probes. The FBI has also published (2020) Quality Assurance Standards for Forensic DNA Testing Laboratories. Retain (4); remains relevant. Numbering removed and title amended as editorial edits.
H-90.987	Equal Access for ~~Physically Challenged~~ Physicians with Physical Disabilities	Our AMA supports equal access to all hospital facilities for ~~physically challenged~~ physicians with physical disabilities as part of the Americans with Disabilities Act. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; remains relevant, with editorial changes in title and body to reflect person-first language.

2. SHORT-TERM MEDICAL SERVICE TRIPS

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

HOUSE ACTION: REFERRED

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad 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. At the same time, short-term medical service trips pose challenges for both volunteers and in prioritizing activities to meet jointly defined goals; navigating day-to-day collaboration across differences of culture, language, and history; and fairly allocating host and team resources in the local setting.

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

THE APPEAL OF SERVING ABROAD

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

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

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

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

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3. AMENDMENT TO OPINION E-9.3.2, "PHYSICIAN RESPONSIBILITIES TO IMPAIRED COLLEAGUES"

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-140.827

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].

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

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

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

CONCLUSION

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

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

RECOMMENDATION

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

> Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.
>
> While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should

strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

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

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

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4. AUGMENTED INTELLIGENCE & THE ETHICS OF INNOVATION IN MEDICINE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals [1,2,3,4].

The AMA Council on Ethical and Judicial Affairs (CEJA) recognizes that AI-based tools can serve a variety of ends in health care, from supporting administrative functions and streamlining institutional operations to enhancing clinical decision making for individual patients [see, e.g., 2,5]. AI systems have strengths and weaknesses across all these areas; in the council's view, the characteristics of systems that are intended to inform diagnosis, predict a patient's clinical course, and support clinical decision making, highlight the risks AI-enabled care can pose to patients and are therefore the primary focus of the present analysis.

CHALLENGES OF AI-ENABLED HEALTH CARE

Several features distinguish the data-driven machine-learning algorithms in clinical prediction models and decision support tools from other innovations in medicine that ethics guidance must take account of: the potential for bias to be built into a model and its outputs; the fact that the most powerful and useful models are both opaque and plastic, that is, they have the capacity to evolve autonomously, outside of human observation and independent of human control. It also requires recognizing that not only do these AI systems involve multiple stakeholders, but that they also "transform the modes of interaction between different agents" [6], creating challenges for devising mechanisms to govern complex AI systems and appropriately hold multiple stakeholders accountable for the performance of those systems.

A Word About Privacy

Protecting the privacy of data subjects and the confidentiality of personal information is frequently cited as a central concern in the use of AI systems [7]. However, such risks are hardly unique to AI. They are common to all activities that collect and store personal information, especially activities that rely on data stored in central repositories—electronic health records, clinical registries, DNA databanks, or tissue banks intended for research use [see, e.g. 8]. The potential for benefit is great but risks that identifiable personal information will be inadvertently disclosed or worse, intentionally misused, are high in all activities that rely on sharing access to data sets that contain such information. For these reasons, the present analysis focuses more narrowly on other features unique to characteristic especially of predictive models and decision support tools that utilize machine-learning algorithms.

Bias

Data-driven machine-learning algorithms are subject to the familiar problem of "garbage in, garbage out." The utility and value of such algorithms is hostage to the quality of the data on which they are trained and with which they are validated. Data drawn from electronic health records (EHRs), on which most such algorithms are currently trained, build into the model itself whatever biases already characterize the data in the record, whether statistical or social [9].

As data sets, EHRs have serious weaknesses. Insofar as they include only information from individuals who have access to the health care system in the first place, and in settings that employ electronic records, they are not representative. Information about individuals who have no or irregular access to care, or whose records exist only in paper form is not available to train or validate an algorithm. Nor are EHR data "pristine"—with rare exceptions, electronic records capture information "downstream" of human judgments, in effect training the algorithm to replicate human cognitive errors as well as any design flaws in the record system itself [9,10].

Even well-intended efforts to correct for possible bias can have unintended consequences. For example, race-adjusted assessments for clinical conditions are often based on the misconception that "race" is a reliable proxy for genetic difference and fail to recognize that "race and health reflect enmeshed social and biologic pathways" [11]. Rather than correct for inequity, these algorithms may direct resources away from patients who are members of minoritized populations and inappropriately propagate race-based medicine instead of the equitable personalized care intended [11]. Moreover, algorithms that are fair out of the box can become biased over time once implemented, affected by characteristics of the contexts, goals, and ways they are deployed [12].

Technical solutions are being explored to mitigate bias before, during, or after an algorithm processes data [9,13].

Opacity & Plasticity

The operation of a machine-learning algorithm can be opaque for any of several reasons. In some cases, this is intentional, such as interest in protecting proprietary information; in others it reflects the fact that being able to read and interpret computer code remains a specialized skill not yet widely shared. A more fundamental challenge, however, lies in understanding highly complex algorithms as they operate on data [14]. The most powerful—and useful—algorithms are "black boxes." As a machine-learning algorithm operates on data its internal decision logic "is altered as the algorithm 'learns'" [14]. Such algorithms have the capacity to evolve in ways that may be impenetrable to human understanding – even to their developers. Because the algorithm's operations "do not naturally accord with human semantic explanations," attempts to provide humanly understandable explanations are "at best incomplete and at worst falsely reassuring" [14]. In this, data-driven AI systems are qualitatively different from other innovations in medicine.

Validation

Robust validation lags the development of AI systems in health care. For example, of some 1366 cardiovascular clinical prediction models (CPM) in the Tufts PACE Clinical Prediction Model registry, fewer than 600 reported at least one validation [15]. Current practice generally assesses only a single model at a time and thus cannot provide "reliable ranking of the comparative performance of the many CPMs available for the same application," which allows a small number of models to dominate clinical practice "based on tradition and herding behavior, rather than high-quality evidence" [15]. Randomized clinical trials that assess the clinical utility of CPMs are rare. Physicians need to be critical consumers of published reports about new AI models, and take into account not only where a report was published, but the source and size of the dataset on which the algorithm was based, whether it was tested on real clinical data, whether its performance was compared to existing solutions, whether it was evaluated for how readily it can be implemented, and whether its results were interpretable to the intended end users [5].

In response to the "current lack of best practice guidance specific to machine learning and artificial intelligence," researchers have proposed 20 key questions to address issues of transparency, reproducibility, ethics, and effectiveness in research involving machine learning and AI [16]. These questions probe issues of inception (e.g., "What is the health question relating to patient benefit"), study design ("Are the data suitable to answer the clinical question…?"), statistical methods, reproducibility, impact (e.g., "Are the results generalizable to settings beyond where the system was developed…?"), and implementation (e.g., "How is the model being regularly reassessed and updated as data quality and clinical practice changes…?").

Oversight & Accountability

Debate continues about whether or to what extent existing models for oversight of medical technologies can be adapted to provide adequate oversight of AI systems in health care. Models for human subjects protections are poorly suited to the evolving "cyber social experiment" [17] represented by machine-learning algorithms, for essentially the same reasons these protections are problematic in contexts of quality improvement activities, or other research that involves

the use of personal health or genetic data or stored biological materials [8]. Nor do machine-learning algorithms fit comfortably within current paradigms for oversight of medical devices, even the Food and Drug Administration's new regulatory framework created under the 21st Century Cures Act [8,18].

Beyond regulatory oversight, the increasing complexity and power of AI systems have prompted calls for the health care organizations that deploy such systems to implement programs of "algorithmic stewardship," analogous to antimicrobial stewardship, "to ensure that algorithms are used safely, effectively, and fairly" [19]. On this model, a designated body within the institution would be tasked with creating and maintaining an inventory of the algorithms deployed within the institution and monitoring the performance of AI systems.

Importantly, inserting AI systems into the process of clinical decision making distributes agency among multiple entities—the patient, the physician, the AI system, its designers, the data set on which it was trained, the institution that deployed it—raising questions about "who is guiding clinical decision-making, in which ways, and on what grounds" [6]. This in turn

> "raises a problem of many hands for ascriptions of responsibility: since a plurality of agents contributes to decision-making guided by AI-DSS [decision support systems], it becomes less clear who is morally and legally answerable in which ways. With the involvement of autonomous, adaptive and learning systems, it becomes harder to ascribe individual responsibility and liability for singular decisions, especially those with adverse outcomes" [6].

FRAMEWORKS FOR ETHICAL AI

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them. Thus, a review prepared by Harvard University's Berkman Klein Center for Internet & Society identified the following as common themes among 36 discussions of "how AI generally *ought* to be developed, deployed, and governed" from governmental agencies, corporations, and private sector organizations [7]:

- Privacy—data subjects have some degree of influence over how and why information about them is used
- Accountability—AI systems should be subject to appropriate oversight during development and deployment, and that appropriate remedies be provided if harm occurs
- Safety and security—AI systems should be reliable and perform as intended, and that systems are appropriately protected against external threats
- Transparency and explainability—it is clear when AI systems are being used and for what task, and that justifications for decision outputs be intelligible
- Fairness and nondiscrimination—steps are taken to prevent and mitigate against discrimination risks in the design, development and application of AI systems
- Human control of technology—important decisions remain subject to human control
- Professional responsibility—individuals and teams involved in the design, development and deployment of AI systems take responsibility for the performance and effects of those systems
- Promotion of human values—the ends to which AI systems are devoted and the means by which they are implemented should correspond with core social norms

The High Level Expert Group on AI of the European Commission identifies five fundamental ethical principles to govern the design and deployment of AI systems [20]:

- Beneficence ("do good")—AI systems should be designed and developed to improve individual and collective well-being.
- Non-maleficence ("do no harm"—By design, AI systems should protect the dignity, integrity, liberty, privacy, safety, and security of human beings … . At the very least, AI systems should not be designed in a way that enhances existing harms or creates new harms for individuals.
- Autonomy ("preserve human agency")—Autonomy of human beings in the context of AI means freedom from subordination to, or coercion by, AI systems. Human beings interacting with AI systems must keep full and effective self-determination over themselves.

- Justice ("be fair")—The principle of justice imparts that the development, use, and regulation of AI systems must be fair. Developers and implementers need to ensure that individuals and minoritized groups maintain freedom from bias, stigmatization, and discrimination.
- Explicability ("operate transparently")—Technological transparency implies that AI systems be auditable, comprehensible and intelligible by human beings at varying levels of comprehension and expertise. Business model transparency means that human beings are knowingly informed of the intention of developers and technology implementers of AI systems.

A report by the Digital Health Learning Collaborative of the National Academy of Medicine similarly identifies beneficence, non-maleficence, autonomy, and justice as fundamental principles for ethical AI in medicine [4].

MOVING FROM PRINCIPLES TO PRACTICE

Recognizing the distinctive challenges AI systems can pose and agreeing on key values and principles that should inform AI systems is essential, but is not enough to guarantee the design, development, and deployment of "ethical AI" in health care or any other domain. As a report by the Gradient Institute has observed, AI systems "possess no intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions" [21].

Algorithms consider only the objectives and constraints supplied by their designers. To embed fundamental ethical considerations into AI systems requires that governing ethical objectives and constraints—for example, "fairness"—be expressed mathematically, as "precise, measurable quantities." For an algorithm to approximate the ethical reasoning a human would bring to bear in making a given decision, its designers must also specify acceptable balances among competing objectives [21]. Further, as some researchers have noted, "analyses of algorithmic fairness in healthcare lack the contextual grounding and causal awareness necessary to reason about the mechanisms that lead to health disparities, as well as about the potential of algorithmic fairness methods to counteract those mechanisms" [22].

Moreover, AI systems must be designed so that the consequences of a system's actions "align with the ethical intent motivating the deployment of the system" [21]. That is, systems must not only be designed in ways that account for bias in training data, but in ways that enable them to apply causal reasoning to model the consequences of its actions and assess the relative likelihood of those consequences occurring. Mathematically representing the kind of multidisciplinary expertise and sensitivity to context that characterize human moral is extremely difficult.

Given these realities, human oversight of AI systems is essential. If overseers are to be able to "anticipate, detect, and correct problems," an AI system must be transparent and interpretable. To reduce the risk that an AI system "will be motivated, designed, or operated in a socially unacceptable way," decisions first must be made about what information needs to be made transparent to whom. The system must further be interpretable in ways that enable people "to understand [a system's] reasoning processes, explain how mistakes occurred, or inform users how to adapt their behavior to obtain different decisions from systems in the future" [21]. Yet, like "fairness," interpretability, often comes at the cost of accuracy, and "determining what attainable compromise between predictive power and effective human oversight results in the best ethical outcomes" will remain a challenge for the foreseeable future.

Finally, Gradient's analysis proposes, oversight and accountability for ethical AI should be sensitive to the complex nature of AI systems and to the multiple contexts in which those systems are used, noting that "labelling requirements, special taxation or regulatory approval processes for 'AI systems' broadly construed" are "unlikely to be helpful" [21]. They propose, instead, sector-specific oversight of the contexts in which AI systems are applied, to permit evidence-based, technically informed regulation that is able to keep pace with rapid, ongoing evolution in the technology.

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

The *AMA Code of Medical Ethics* defines fidelity to patients and physicians' corresponding responsibility to promote patients' well-being as the core value of medicine as a profession. Opinion 1.1.1, "Patient-Physician Relationships," holds that

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for patients' welfare.

Innovations in health care should sustain this fundamental commitment of fidelity to patients. Those who design and deploy new interventions or technologies, particularly interventions or technologies intended to directly interface with decisions about patient care, have a responsibility to ensure that their work serves the goals of medicine as a priority. Thus Opinion 1.2.11, "Ethically sound innovation in medical practice," provides that any given innovation must be scientifically well grounded and focus on the interests of patients, not those of innovators or health care institutions.

Guidance in Opinion 1.2.11 further recognizes that introducing new technologies or other innovation into medical practice poses challenges at the systemic level as well as for individual physicians. Strong practice requires attention not only to individual clinical interactions "at the bedside," but equally to the organizational policies, practices, and infrastructure of health care institutions that deploy a medical innovation. Innovators have a responsibility to engage stakeholders early in the process and must consciously design innovations to minimize risks to individual patients and maximize the likelihood they will be adopted and will benefit populations of patients. Innovators also have an ethical obligation to be sensitive to the cost implications of innovation and aware of influences that may drive the creation and adoption of innovations for reasons other than patient or public benefit. Institutions and physician practices that adopt innovations have a responsibility to ensure that appropriate infrastructure is in place to support effective implementation and oversight.

Guidance in Opinion 11.2.1,"Professionalism in Health Care Systems," sets out the responsibilities of physician-leaders to create conditions that support physician professionalism within their organizations, including responsibilities to ensure that institutional arrangements that govern care are transparent and that decisions reflect input from key stakeholders. It defines leaders' responsibilities to ensure that mechanisms adopted to influence physician decision making are "designed in keeping with sound principles and solid scientific evidence," deployed fairly so that they "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities." It further holds physician-leaders responsible to ensure the institution provides avenues "for meaningful appeal and advocacy on behalf of patients" and for monitoring deployment of new practices and tools to identify and respond to their effects on patient care.

ASKING THE RIGHT QUESTIONS

The majority of physicians will be consumers of AI systems developed by others—including even those physicians who are affiliated with institutions that are actively engaged in developing AI for health care. As individual end users, physicians cannot reasonably be expected to have the requisite skills or opportunity to evaluate AI systems, and should not be, any more than they are expected to make firsthand assessment of other diagnostic or therapeutic innovations. They must rely on their institutions—or the vendors from whom they purchase AI systems for their practices—to ensure that those systems are trustworthy.

Ethically appropriate use of AI in health care must support, not subvert, the goals and values that define medicine as a profession. Physicians should be thoughtful consumers of AI and recognize that they have a responsibility to use their voice as professionals and their knowledge of their patients' needs to help inform decisions about what AI systems will be implemented in the care settings in which they practice. They should be able to expect that health care institutions with which they are affiliated can answer the following questions when deploying an AI system that will affect clinical practice:

- What recognized clinical need among our patient population is this tool intended to address?
- Has it been rigorously demonstrated to successfully meet that need among patients relevantly similar to ours in comparable clinical settings?
  - By whom?
- What is the worst that could happen to the person who is most adversely affected if we deploy this system?
  - Are those who are most likely to be adversely affected already disadvantaged compared to others?
  - How will the institution minimize the possibility of a "worst case" scenario occurring?
- Through what process and by whom was the decision made to acquire and deploy this technology at this time?

- What resources, in both personnel and infrastructure, are needed to deploy this technology successfully?
  - How will the institution ensure that these resources are available?
- How will the institution monitor the performance of this system once it is deployed?
  - Are there clear protocols for clinicians to contribute to performance assessment? To regularly receive information about the system's impact on patient care/outcomes?
- How will the institution support my exercise of professional clinical judgment and expertise with respect to clinical predictions or treatment recommendations generated by this AI system?

CONCLUSION

As the foregoing analysis indicates, the introduction of augmented intelligence systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in future reports.

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

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

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

APPENDIX – CEJA Judicial Function Statistics, April 1, 2020 – March 31, 2021

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
10	Determinations of no probable cause
22	Determinations following a plenary hearing
7	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
10	No sanction or other type of action
5	Monitoring
6	Probation
1	Revocation
7	Suspension
1	Denied
1	Suspension lifted
3	Censure
2	Reprimand
3	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
6	Members placed on Probation/Monitoring during reporting interval
6	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation
48	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
18	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues