

## OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinions were presented by Alexander M. Rosenau, DO, Chair:

### 1. AMENDMENT TO E-1.1.6, “QUALITY”

*CEJA Opinion; no reference committee hearing.*

#### HOUSE ACTION: FILED

#### INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, “Amendments to Opinions 1.2.11, ‘Ethical Innovation in Medical Practice’; 11.1.2, ‘Physician Stewardship of Health Care Resources’; 11.2.1, ‘Professionalism in Health Care Systems’; and 1.1.6, ‘Quality.’” 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-1.1.6, Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- (a) Keeping current with best care practices and maintaining professional competence.
- (b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (c) Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.
- (d) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
- (e) Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
- (f) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

### 2. AMENDMENT TO E-1.2.11, “ETHICAL INNOVATION IN MEDICAL PRACTICE”

*CEJA Opinion; no reference committee hearing.*

#### HOUSE ACTION: FILED

#### INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, “Amendments to Opinions 1.2.11,

‘Ethical Innovation in Medical Practice’; 11.1.2, ‘Physician Stewardship of Health Care Resources’; 11.2.1, ‘Professionalism in Health Care Systems’; and 1.1.6, ‘Quality.’” 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-1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can span a wide range of activities. It encompasses not only improving an existing intervention, using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, or interventions they employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.
- (d) Be sensitive to the cost implications of innovation.
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

- (f) Base recommendations on patients’ medical needs.
- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills.
- (h) Recognize that in this context informed decision making requires the physician to disclose:
  - (i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;
  - (ii) why the physician is recommending the innovative modality;
  - (iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;
  - (iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;
  - (v) what conflicts of interest the physician may have with respect to the recommended therapy.
- (i) Discontinue any innovative therapies that are not benefiting the patient.

- (j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

- (k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.
- (l) Require that physicians who adopt innovations into their practice have relevant knowledge and skills.
- (m) Provide meaningful professional oversight of innovation in patient care.
- (n) Encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably.

### 3. AMENDMENT TO E-11.1.2, “PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES”

*CEJA Opinion; no reference committee hearing.*

#### HOUSE ACTION: FILED

#### INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, “Amendments to Opinions 1.2.11, ‘Ethical Innovation in Medical Practice’; 11.1.2, ‘Physician Stewardship of Health Care Resources’; 11.2.1, ‘Professionalism in Health Care Systems’; and 1.1.6, ‘Quality.’” 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-11.1.2, Physician Stewardship of Health Care Resources

Physicians’ primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians’ primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

- (a) Base recommendations and decisions on patients’ medical needs.
- (b) Use scientifically grounded evidence to inform professional decisions when available.
- (c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
- (d) Endorse recommendations that offer reasonable likelihood of achieving the patient’s health care goals.
- (e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
- (f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

- (g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

- (h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
- (i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.
- (j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.
- (k) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

#### 4. AMENDMENT TO E-11.2.1, “PROFESSIONALISM IN HEALTH CARE SYSTEMS”

*CEJA Opinion; no reference committee hearing.*

#### HOUSE ACTION: FILED

#### INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, “Amendments to Opinions 1.2.11, ‘Ethical Innovation in Medical Practice’; 11.1.2, ‘Physician Stewardship of Health Care Resources’; 11.2.1, ‘Professionalism in Health Care Systems’; and 1.1.6, ‘Quality.’” 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-11.2.1, Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients’ choices, the patient-physician relationship, and physicians’ relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians’ exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should:

- (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
- (b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
- (c) Ensure that all such tools:
  - (i) are designed in keeping with sound principles and solid scientific evidence.
    - a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.
    - b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.
    - c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.
  - (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
  - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
  - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
- (d) Encourage, rather than discourage, physicians (and others) to:
  - (i) provide care for patients with difficult to manage medical conditions;
  - (ii) practice at their full capacity, but not beyond.
- (e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
- (f) Ensure that the use of financial incentives and other tools is routinely monitored to:
  - (i) identify and address adverse consequences;
  - (ii) identify and encourage dissemination of positive outcomes.

All physicians should:

- (g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
- (h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

## REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Alexander M. Rosenau, DO, Chair:

### 1. 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 been promoted, in part, as a strategy for addressing global health inequities. Without question, such trips have benefitted thousands of individual patients. At the same time, short-term medical service trips have a problematic history and run the risk of causing harm to the patients and communities they intend to serve [1]. To minimize harm and maximize benefit volunteers, sponsors, and hosts must jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting.

Ethics guidance alone can neither redress historical wrongs nor solve the underlying structural issues that drive medical need in resource-limited settings of course. But by making explicit the conditions under which short-term medical service trips are ethically sound and by articulating the fundamental ethical responsibilities of those who participate in or sponsor such trips, ethics guidance can promote immediate benefit to individuals *and* sustainable benefit for their communities. This report by the Council on Ethical and Judicial Affairs (CEJA) explores the challenges of short-term medical service trips and offers guidance for physicians, physicians in training, and sponsors to help them address ethical challenges of providing clinical care in resource-limited settings abroad.

#### THE APPEAL OF SHORT-TERM MEDICAL SERVICE TRIPS

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 [2]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [3]. 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 [4].

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 [2]. 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 [2].

#### 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” [5], “short-term medical missions” [6], “short-term medical service trips” [7,8], “short-term experience in global health” [9,10], “global health field experience” [11], “global health experience,” and “international health experience” [2]. 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 [10]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [9]. Many now also offer training opportunities for medical students and residents [9,10,11]. 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 [9,10].

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” [7]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are “victims of social, economic, or environmental factors” who have limited access to health care [7], and often lack access to food, and economic and political power as well and “may feel unable to say no to charity in any form offered” [10]. Moreover, short-term medical service trips take place under the long shadow of colonialism, including medicine's role [12], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [1,10,13].

## ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities 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 to maximize and enhance good clinical outcomes, to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [2,9,10,11].

### *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 [7,9]. Trips should seek to balance community priorities with the training interests and abilities of participants [10], but in the first instance benefits should be those desired by the host community [9]. Likewise, interventions must be acceptable to the community [9].

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 [7]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [7,10].

### *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 [9], 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 [9,11]. 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 [7].

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 [11]. 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 [11].

### *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 [1,2,9]. 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 [7,10,11].

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 [11], 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” [9]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [14]. 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 [15].

### 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 [1,2, 9,11].

### *Prepare Diligently*

Guidelines from the American College of Physicians recognize that “predeparture preparation is itself an ethical obligation” [9, cf. 2]. 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 [11].

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” [10].

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 [7]. 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 [1,2,7]. 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 [7]. 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” [9]. 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 [9,10,11]. 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 [10].

### *Measure & Share Meaningful Outcomes*

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program outcomes should be appropriate to the program’s goals as defined proactively in collaboration with the host community [9]; for example, some have suggested quality-adjusted life years (QALYs) [16]. 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 [7]. 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 been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer 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 in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of participants and sponsors 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 practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for appropriate supervision of trainees, 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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## 2. AMENDMENT TO OPINION 10.8, COLLABORATIVE CARE

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

### HOUSE ACTION: REFERRED

Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as “Doctor of Nursing.” Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner’s skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

### DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term “nonphysician practitioners” denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are “multiple pathways” for one to become a nonphysician practitioner, the most common is a nurse earning a “master’s degree or doctoral degree in nursing” after initial completion of a bachelor’s degree [1]. However, the skillsets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as “Doctor” consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

### PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggests that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in “recent years, an explosion of doctorates in various medical professions has made the label of ‘doctor’ far less clear”, a common example being that of the “Doctor of Nursing Practice” (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a “political maneuver, designed to appropriate the title of ‘doctor’ and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public” [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be “addressed as ‘doctor’ if the DNP clarifies that he or she is actually an NP” and some jurisdictions require NPs without a doctorate to have special identification that “unambiguously identifies them” [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient’s autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient’s decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner’s skill set, education, and experience.

#### GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

##### *House Policy*

[H-405.992](#) – “Doctor as Title,” states:

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title “Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

[D-405.991](#) – “Clarification of the Title “Doctor” in the Hospital Environment,” states:

Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

[H-405.969](#) – “Definition of a Physician”, states:

... a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the AMA definition above, must specifically and simultaneously declare themselves a “non-physician” and define the nature of their doctorate degree.

*Code of Medical Ethics*

The Code already addresses transparency in context of residents and fellows. [Opinion 9.2.2](#), “Resident & Fellow Physicians' Involvement in Patient Care,” possesses some language regarding transparency and identification where it states:

When they are involved in patient care, residents and fellows should:

- (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, [Opinion 10.8](#), “Collaborative Care” is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

## RECOMMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, Collaborative Care be amended as follows and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting and promoting the integrity of the patient-professional ~~physician~~ relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to patient-professional relationships, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient’s care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

- (a) Model ethical leadership by:
  - (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
  - (ii) Clearly articulating individual responsibilities and accountability
  - (iii) Encouraging insights from other members and being open to adopting them and
  - (iv) Mastering broad teamwork skills
- (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.
- (c) Help clarify expectations to support systematic, transparent decision making.

- (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.
- (e) Communicate appropriately with the patient and family, including being forthright when describing their profession and role, and respecting the unique relationship of patient and family as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

- (f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
- (g) Encourage their institutions to identify and constructively address barriers to effective collaboration.
- (h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.
- (i) Promote a culture of respect, collegiality and transparency among all health care personnel.

#### REFERENCES

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### 3. AMENDMENT TO E-9.3.2, “PHYSICIAN RESPONSIBILITIES TO COLLEAGUES WITH ILLNESS, DISABILITY OR IMPAIRMENT”

*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-140.825*

#### INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted Policy D-140.952, “AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues,” asking the Council to consider specific amendments to guidance adopted by the House at its June 2021 Special Meeting as follows:

- (i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

with additional guidance

- (k) Advocating for fair, objective, external, and independent evaluations for physicians when a review is requested or required to assess a potential impairment and its duration by an employer, academic medical

center, or hospital/health system where said physician has clinical privileges or where said physician-in-training is placed for a clinical rotations.

The Council thanks the House for offering these clarifications and fully concurs with the importance of ensuring fair assessment of any potential impairment.

## RECOMMENDATION

The Council believes that a more general formulation that did not delineate specific actors would better emphasize the importance of fairness whenever and by whomever such assessment is sought and would help ensure that guidance remains evergreen. The Council therefore proposes to amend Opinion 9.3.2 by insertion as follows:

### E-9.3.2 – Physician Responsibilities to Colleagues with Illness, Disability or Impairment

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, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

- (j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to that will ensure patient safety and practice competency. (II)

#### 4. CEJA'S SUNSET REVIEW OF 2012 HOUSE POLICIES

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

#### HOUSE ACTION: RECOMMENDATIONS ADOPTED 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
<a href="#">D-478.978</a>	Electronic Health Record "Lemon Law"	Our AMA will pursue possibilities, consistent with our strategic direction and existing guidelines for working with third parties, to develop tools, accessible to all AMA members, which can help physicians in the selection and evaluation of electronic health records. (BOT Rep. 9, A-12)	Retain; remains relevant.



<a href="#">D-85.995</a>	Medical Examiner Patient Postmortem: Cause of Death Transparency	Our AMA will: (1) convene a study group to examine strategies to implement a postmortem process or standard for ongoing communication between the medical examiner, physicians, health care providers, and family members; and (2) develop guidelines for hospital processes for communication between medical examiners, clinicians, families, medical staffs, and other key stakeholders to establish a postmortem management methodology that includes timely communication between all parties. (Res. 726, A-12)	Rescind; directive was fulfilled. A study group was convened and resultant guidelines can be found <a href="#">here</a> .
<a href="#">H-235.977</a>	Medical Staff Committees to Assist Impaired or Distressed Physicians	Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	Retain; remains relevant.
<a href="#">H-370.971</a>	Increasing Organ Donation	Our AMA recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care. (CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
<a href="#">H-370.975</a>	Ethical Issues in the Procurement of Organs Following Cardiac Death	<p>The Pittsburgh Protocol: The following guidelines have been adopted:</p> <p>The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended:</p> <p>(a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation.</p> <p>(b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that they may decide with their physicians whether to accept the organs or wait for more suitable ones.</p> <p>(c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol. (CEJA Rep. 4 - I-94; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CEJA Rep. 3, A-12)</p>	Rescind; while the policy remains relevant, it has been superseded by formal ethics policy at <a href="#">Opinion 6.1.2</a> – “Organ Donation After Cardiac Death.”

<a href="#">H-370.982</a>	<p>Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients</p>	<p>Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.</p> <p>(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.</p> <p>(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.</p> <p>(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.</p> <p>(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.</p> <p>(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.</p> <p>(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99;</p>	<p>Retain; remains relevant. Policy is further complimented by ethics policy at <a href="#">Opinion 11.1.3</a> – "Allocating Limited Health Care Resources."</p>
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		Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12)	
<a href="#">H-370.983</a>	Tissue and Organ Donation	Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. (Res. 533, A-92; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
<a href="#">H-370.986</a>	Donor Tissues and Organs for Transplantation	The AMA strongly urges physicians or their designees to routinely contact their hospital's designated tissue or organ procurement agency (as appropriate), at or near the time of each patient's death, to determine the feasibility of tissue and/or organ donation. (Res. 103, I-90; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
<a href="#">H-370.990</a>	Transplantable Organs as a National Resource	Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy. (Res. 94, I-87; Reaffirmed: Sunset Report, I-97; Appended and Reaffirmed CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
<a href="#">H-370.995</a>	Organ Donor Recruitment	Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors; (2) the success rate for organ transplantation; (3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and (6) the ethical considerations of organ donor recruitment. (Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
<a href="#">H-370.998</a>	Organ Donation and Honoring Organ Donor Wishes	Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs. (CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.

## 5. PANDEMIC ETHICS AND THE DUTY OF CARE (POLICY D-130.960)

*Informational report; no reference committee hearing.*

### HOUSE ACTION: REFERRED

Policy D-130.960, “Pandemic Ethics and the Duty of Care,” adopted by the American Medical Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial Affairs to “reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.”

### A CONTESTED DUTY

As several scholars have noted, the idea that physicians have a professional duty to treat has waxed and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled the Black Death; those who remained did so out of religious devotion, or because they were enticed by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians contested whether they had a responsibility to put themselves at risk for what was then a lethal and poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in 1847 codified a clear expectation that physicians would accept risk:

When pestilence prevails, it is [physicians’] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives [[1847 Code](#), p. 105].

That same sensibility informs AMA’s [Declaration of Professional Responsibility](#) when it calls on physicians to “apply our knowledge and skills when needed, though it may put us at risk.” And it is embedded in current guidance in the *Code*. Based on physicians’ commitment of fidelity to patients, [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness,” enjoins a duty to treat. This opinion provides that “individual physicians have an obligation to provide urgent medical care during disasters . . . even in the face of greater than usual risks to physicians’ own safety, health, or life.” The *Code* is clear that this obligation isn’t absolute, however. Opinion 8.3 qualifies the responsibility when it notes that “physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.”

From the perspective of the *Code*, then, the question isn’t whether physicians have a duty to treat but how to think about the relative strength of that duty in varying circumstances.

### INTERPRETING ETHICS GUIDANCE

Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat [unvaccinated patients](#) and under what conditions medical students may ethically be permitted to [graduate early](#) to join the physician workforce. Drawing particularly on guidance in [Opinion 1.1.2](#), “Prospective Patients,” and—in keeping with Opinion 8.3, taking physicians’ expertise and availability as itself a health care resource—[Opinion 11.1.3](#), “Allocating Limited Health Care Resources,” as well as [Opinion 8.7](#), “Routine Universal Immunization of Physicians,” these analyses offer key criteria for assessing the strength of the duty to treat:

- urgency of medical need
- risk to other patients or staff in a physician’s practice
- risk to the physician
- likelihood of occurrence and magnitude of risk

To these criteria should be added likelihood of benefit—that is, physicians should not be obligated to put themselves at significant risk when patients are not likely to benefit from care [2]. Although the *Code* does not link the question specifically to situations of infectious disease or risk to physicians, it supports this position. [Opinion 5.5](#), “Medically Ineffective Interventions,” provides that physicians are not obligated to provide care that, in their considered professional judgment, will not provide the intended clinical benefit or achieve the patient’s goals for care.

Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to protect the well-being of patients and staff, it supports consideration of risk to others in assessing the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians from declining a patient based solely on the individual's disease status, it permits them to decline to provide care to patients who threaten the well-being of other patients or staff. In the context of a serious, highly transmissible disease this responsibility to minimize risk to others in professional settings may constrain the presumption of a duty to treat.

Yet the *Code* is also silent on important matters that have been noted in the literature. For example, it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some scholars argue that the obligation should be understood as conditioned by physicians' expertise, training, and role in the health care institution [4,5,6]. In essence, the argument is that the more relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to expect physicians to accept greater personal risk than clinicians who don't have the same expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the exclusive province of any individual health profession" [2], risks undercutting its own value to offer insight into that duty.

Moreover, for the most part the *Code* restricts its analysis of physicians' responsibilities to the context of their professional lives, addressing their duties to patients, and to a lesser degree, to their immediate colleagues in health care settings. In this, guidance overlooks the implications of responsibilities physicians hold in their *nonprofessional* lives—as members of families, as friends, as participants in community outside the professional domain. Thus, it is argued, a physician whose household includes a particularly vulnerable individual—e.g., someone who has chronic underlying medical condition or is immune compromised and thus at high risk for severe disease—has a less stringent duty to treat than does a physician whose personal situation is different.

Although the *Code* acknowledges that physicians indeed have lives as moral agents outside medicine ([Opinion 1.1.7](#), "Physician Exercise of Conscience"), it does not reflect as deeply as it might about the nature of competing personal obligations or how to balance the professional and the personal. In much the same way as understanding the duty to treat as the responsibility of a single profession, restricting analysis to a tension between altruism and physicians' individual self-interest "fails to capture the real moral dilemmas faced by health care workers in an infectious epidemic" [7].

## SUPPORTING THE HEALTH CARE WORKFORCE

As adopted in 1847, the *Code* addressed physicians' ethical obligations in the broader framework of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code* came to focus primarily on physician conduct.

Pandemic disease doesn't respect conceptual boundaries between the professional and the personal, the individual and the institutional. Nor does it respect the borders of communities or catchment areas. In situations of pandemic disease, "the question is one of a social distribution of a biologically given risk within the workplace and society at large" [7].

### *Health Care Institutions*

Under such conditions, it is argued, the duty to treat "is not to be borne solely by the altruism and heroism of individual health care workers" [7]. Moreover, as has been noted,

... organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on institutions' responsibility to the communities they serve ([Opinion 11.2.6](#), "Mergers between Secular and Religiously Affiliated Health Care Institutions"), and to the needs of physicians and other health care personnel who staff them (Opinions [11.1.2](#), "Physician Stewardship of Health Care Resources," and [11.2.1](#), "Professionalism in Health Care Systems). Health care facilities and institutions are the locus within which the practice of today's complex health care takes place. As such, institutions—notably nonprofit institutions—too have duties,

... fidelity to patients, service to patients, ensuring that the care is high quality and provided “in an effective and ethically appropriate manner”; service to the community the hospital serves, deploying hospital resources “in ways that enhance the health and quality of life” of the community; and institutional stewardship [[CEJA 2-A-18](#)].

Analyses posted to the AMA’s COVID-19 Resource Center look to this guidance to examine institutional obligations to [protect health care personnel](#) and to respect physicians who voice concern when institutional [policies and practices](#) impinge on clinicians’ ability to fulfill their ethical duties as health care professionals.

Although existing guidance does not explicitly set out institutional responsibility to provide appropriate resources and strategies to mitigate risk for health care personnel, it does support such a duty. The obligation to be responsible stewards of resources falls on health care institutions as well as individuals. To the extent that health care professionals themselves are an essential and irreplaceable resource for meeting patient and community needs, institutions have an ethical duty to protect the workforce (independent of occupational health and safety regulation). On this view, institutions discharge their obligations to the workforce when, for example, they

- support robust patient safety and infection control practices
- make immunization readily available to health care personnel
- provide adequate supplies of appropriate personal protective equipment (PPE)
- ensure that staffing patterns take into account the toll that patient care can exact on frontline clinicians
- distribute burdens equitably among providers in situations when individual physicians or other health care personnel *should not* put themselves at risk
- have in place fair and transparent mechanisms for responding to individuals who decline to treat on the basis of risk. (Compare Opinion 8.7, “Routine Universal Immunization of Physicians.”)

Equally, institutions support staff by gratefully acknowledging the contributions all personnel make to the operation of the institution and providing psychosocial support for staff.

### *Professional Organizations*

So too physicians and other health care professionals should be able to rely on their professional organizations to advocate for appropriate support of the health care workforce, as in fact several [organizations](#) have done over the course of the COVID-19 pandemic. In March 2020, the American Medical Association, American Hospital Association, and American Nurses Association, for example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA) to [provide PPE](#). The [American College of Physicians](#) similarly urged use of the DPA to address the shortage of PPE. [Physicians for Human Rights](#) led a coalition of organizations that called on the National Governors Association to urge governors to implement mandatory standards for protecting health workers during the pandemic.

The AMA further advocated for opening [visa processing](#) for international physicians to help address workforce issues, and secured [financial support](#) for physician practices under the Provider Relief Fund of the American Rescue Plan Act.

### *Public Policy*

As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and society. Such obligations on the part of communities and public policymakers should be acknowledged as among the main factors that “contour the duty to treat” [1]. More specifically, it is argued,

in preparation for epidemics communities should: 1) take all reasonable precautions to prevent illness among health care workers and their families; 2) provide for the care of those who do become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and 4) provide reliable compensation for the families of those who die while fulfilling this duty [1].

In the face of the failure on the part of health care institutions and public agencies to ensure that essential resources have been in place to reduce risk and lessen the burdens for individuals of taking on the inevitable risk that remains, it is understandable that physicians and other health care professionals may resent the expectation that they will unhesitatingly put themselves at risk. At least one scholar has forcefully argued that, in the case of COVID-19,



celebrations of medical heroism were overwhelmingly insensitive to the fact such heroism was the “direct, avoidable consequence” of institutional and public policy decisions that left the health care system unprepared and transferred the burden of responding to the pandemic to individual health care professionals [8].

#### ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

In the end, seeing the duty to treat as simply a matter of physicians’ altruistic dedication to patients forecloses considerations that can rightly condition the duty in individual circumstances. As Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians only obligation in a public health crisis. They equally have an obligation to be part of ensuring that care can be provided in the future. Equating duty to treat with altruism “makes invisible moral conflicts between the various parties to whom a person may owe care, and interferes with the need of healthcare professionals to understand that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic” [7].

Further, such a view not only elides institutional and societal obligations but misrepresents how the duty actually plays out in contemporary health care settings. The risks posed by pandemic disease are distributed across the health care workforce, not uniquely borne by individuals, let alone by individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an obligation physicians owe to fellow health care personnel as much as to patients or to society.

#### AN ENDURING PROFESSIONAL RESPONSIBILITY

Taken together, the foregoing considerations argue that physicians indeed *should* recognize the duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of one’s ethical obligations

... requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Decisions to decline a duty to treat during a public health crisis carry consequences well beyond the immediate needs of individual patients. In exercising the required discernment and ethical reflection, physicians should take into account:

- the urgency of patients’ medical need and likelihood of benefit
- the nature and magnitude of risks to the physician and others to whom the physician also owes duties of care
- the resources available or reasonably attainable to mitigate risk to patients, themselves and others
- other strategies that could reasonably be implemented to reduce risk, especially for those who are most vulnerable
- the burden declining to treat will impose on fellow health care workers

Physicians who themselves have underlying medical conditions that put them at high risk for severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at high risk, have a responsibility to protect themselves as well as their patients. But protecting oneself and one’s patients carries with it a responsibility to identify and act on opportunities to support colleagues who take on the risk of providing frontline care.

Physicians and other health care workers *should* be able to rely on the institutions within which they work to uphold the organization’s responsibility to promote conditions that enable caregivers to meet the ethical requirements of their professions. So too, physicians and other health care workers *should* be able to trust that public policymakers will make and enforce well-considered decisions to support public health and the health care workforce. When those expectations are not met, physicians have a responsibility to advocate for change [[Principles III, IX](#)].

Yet, grounded as it is in physicians’ commitment of fidelity to patients, the professional duty to treat ultimately overrides the failure of institutions or society.

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## 6. 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 [ama-assn.org/governing-rules](http://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, 2021 – March 31, 2022

Physicians Reviewed	<u>SUMMARY OF CEJA ACTIVITIES</u>
2	Determinations of no probable cause
27	Determinations following a plenary hearing
14	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing



Physicians Reviewed	<u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u>
4	No sanction or other type of action
2	Monitoring
11	Probation
5	Revocation
5	Suspension
0	Denied
0	Suspension lifted
1	Censure
7	Reprimand
8	Admonish

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