

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

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

- 02 New Specialty Organizations Representation in the House of Delegates
- 13 Use of Psychiatric Advance Directives
- 14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 21 Opposition to Requirements for Gender-Based Treatments for Athletes

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

- 01 Clarification to the Bylaws: Delegate Representation

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

- 01 Short-Term Medical Service Trips
- 02 Amendment to Opinion 10.8, Collaborative Care
- 03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment
- 04 CEJA's Sunset Review of 2012 House Policies

### **Resolution(s)**

- 001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
- 002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers
- 003 Gender Equity and Female Physician Work Patterns During the Pandemic
- 004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
- 005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 007 Equal Access for Adoption in the LGBTQ Community
- 008 Student-Centered Approaches for Reforming School Disciplinary Policies
- 009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
- 010 Improving the Health and Safety of Sex Workers
- 011 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-A-22

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the  
2 applications of the American Contact Dermatitis Society, American Society of Regional  
3 Anesthesia and Pain Medicine, Americas Hernia Society, and the Outpatient Endovascular and  
4 Interventional Society for national medical specialty organization representation in the American  
5 Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by  
6 the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

7  
8 The applications were considered using criteria developed by the Council on Long Range Planning  
9 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

10  
11 Organizations seeking admission were asked to provide appropriate membership information to the  
12 AMA. That information was analyzed to determine AMA membership, as required under  
13 criterion 3. A summary of this information is attached to this report as Exhibit B.

14  
15 In addition, organizations must submit a letter of application in a designated format. This format  
16 lists the above-mentioned guidelines followed by each organization's explanation of how it meets  
17 each of the criteria.

18  
19 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.  
20 These four organizations have actively participated in the SSS for more than three years.

21  
22 Review of the materials and discussion during the SSS meeting at the 2021 June and November  
23 Special Meetings indicated that the American Contact Dermatitis Society, American Society of  
24 Regional Anesthesia and Pain Medicine, Americas Hernia Society, and the Outpatient  
25 Endovascular and Interventional Society meet the criteria for representation in the HOD.

### 26 27 RECOMMENDATION

28  
29 Therefore, the Board of Trustees recommends that the American Contact Dermatitis Society,  
30 American Society of Regional Anesthesia and Pain Medicine, Americas Hernia Society, and the  
31 Outpatient Endovascular and Interventional Society be granted representation in the AMA House  
32 of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX  
Exhibit A

**GUIDELINES FOR REPRESENTATION IN & ADMISSION TO  
THE HOUSE OF DELEGATES:**

**National Medical Specialty Societies**

- 1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
- 2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
- 3) The organization must meet one of the following criteria:
  - 1,000 or more AMA members;
  - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
  - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
- 4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.
- 5) Physicians should comprise the majority of the voting membership of the organization.
- 6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.
- 7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.
- 8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
- 9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
- 10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

**RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS**

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

***Exhibit B - Summary Membership Information***

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Contact Dermatitis Society	313 of 930 (34%)
American Society of Regional Anesthesia and Pain Medicine	955 of 3,603 (27%)
Americas Hernia Society	217 of 1,006 (22%)
Outpatient Endovascular and Interventional Society	101 of 250 (40%)

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-22

Subject: “Use of Psychiatric Advance Directives”  
(Resolution 1-I-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution & Bylaws

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At the 2019 Interim Meeting, the American Medical Association (AMA) House of Delegates referred to the Board of Trustees Resolution 1-I-19, “Support for the Use of Psychiatric Advances Directives,” which was introduced by the Medical Student Section. Resolution 1-I-19 asked:

That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

Testimony supported referral of the resolution. Speakers noted that the use of psychiatric advance directives (PAD) is a complex issue that requires study of situations where PADs may be overridden, such as directives that are not aligned with standards of care or patients who pose a risk to public safety. This report reviews evidence currently available in this area from governmental agencies, academic institutions, and scholarly and popular publications.

### DEFINITION & BACKGROUND

Psychiatric advance directives (PADs) are legally binding documents (with certain exceptions as noted below) that allow psychiatric patients to direct, while they are well, future decisions about mental health care should they lose the ability to do so due to their psychiatric illness [1]. Such directives may specify but are not limited to, patient preferences regarding types of medications, seclusion and/or restraints, and electroconvulsive therapy. PADs also include the designation of a surrogate decision maker or health care proxy [2]; who ideally works with the patient and physician to complete the PAD.

Studies suggest that “if given the choice and necessary assistance, one-half to one-third of patients with severe mental illness would complete a psychiatric advance directive” [3]. Use of PADs is supported by several mental health and patient advocacy organizations, including the [National Alliance on Mental Illness](#) (NAMI), [Mental Health of America](#), and the [National Coalition for Mental Health Recovery](#). These organizations emphasize the value of PADs for patient autonomy and self-determination. As NAMI explains, “PADs help an individual with mental illness preserve their autonomy while ensuring the right care at the right time,” while also helping to prevent “involuntary treatment.”

Nonetheless, only between 4% and 13% of patients who receive public sector mental health benefits have executed a PAD. Individual barriers to completing a PAD include difficulty understanding advance directives and challenges in completing them, such as the complexity of

1 legal forms and challenges of obtaining witnesses and having documents notarized and  
 2 appropriately filed [3]. There are also system-level barriers, such as lack of staff awareness or  
 3 communication among staff across complex mental health systems, and lack of access to the  
 4 documents during a crisis [3].

5  
 6 The goal of PADs is to provide patients with the opportunity for increased autonomy regarding  
 7 their mental health care, and, ideally to increase collaboration and alliance between the patient and  
 8 their physician [2]. Studies suggest that this is the case [2], and that PADs can increase treatment  
 9 adherence after discharge [3,4], and lower the likelihood of coerced treatment [5]. Patients with  
 10 PADs also report that their “need for mental health treatment had been met” [3].

11  
 12 However, these studies do not identify whether it was the process of discussing treatment options  
 13 and creating a PAD or the use of the directive to make treatment decisions that most influenced  
 14 these outcomes. For example, research on facilitated advance directives [3] did not identify  
 15 whether it was the conversation necessary to complete a PAD that provided the most benefit, or the  
 16 actual execution of the PAD. Further, it is unknown if the physician’s familiarity with a patient had  
 17 any influence on outcomes. To best promote the goals of PADs, it would be valuable to know the  
 18 relative contribution of (1) the process of creating a PAD through in-depth conversation and  
 19 consideration of treatment options, (2) familiarity with the patient’s history, and (3) the use of a  
 20 PAD in making actual treatment decisions for patients in crisis. Further research in this area seems  
 21 warranted.

22  
 23 Studies have shown that facilitated PADs virtually always align with standards of care. For patients  
 24 deemed to pose a danger to themselves or others, a PAD does not “supersede the legal authority  
 25 established by state civil commitment statutes or the authority of the court” [2].

## 26 27 ETHICALLY SALIENT DIFFERENCES BETWEEN PSYCHIATRIC & MEDICAL ADVANCE 28 DIRECTIVES

29  
 30 Both psychiatric and medical advance directives promote patient autonomy by allowing an  
 31 individual with decision-making capacity to make known their preferences for future care in the  
 32 event they become unable to participate in care decisions. However, medical and psychiatric  
 33 advance directives differ in ethically significant ways.

34  
 35 Medical advance directives (MADs) govern decisions about life-sustaining interventions in  
 36 contexts of terminal illness or catastrophic injury. To this extent, they address the timing and  
 37 circumstances of a foreseeable death. PADs, however, govern treatment decisions during episodes  
 38 of care in relapsing mental health conditions [6], the expected outcome of which is a return to  
 39 baseline behavior, baseline function, or some other stable end point [6]. Importantly, patients who  
 40 execute PADs have firsthand experience and knowledge of interventions that most patients who  
 41 execute MADs do not. They have been able to form clear preferences that can be expressed in a  
 42 PAD.

43  
 44 The patient’s ability to communicate also distinguishes MADs from psychiatric directives. In  
 45 situations of terminal illness or catastrophic injury, patients often experience significant  
 46 impairment or total loss of the ability to communicate [6]. If a patient with a MAD regains the  
 47 ability to communicate, their stated wishes in the moment supersede the instructions in their  
 48 advance directive. Interpreting a psychiatric patient’s coherently articulated wishes when they  
 49 conflict with the instructions in a PAD is more challenging. Contemporaneously expressed wishes  
 50 may reflect the patient’s relapsing mental illness, not the wishes expressed when the patient was  
 51 not in crisis and do not automatically supersede the directive. In such situations, physicians must

1 evaluate the patient's immediate versus overall best interest and the consequences of overriding the  
2 PAD, including the effect any decision may have on trust in the patient-physician relationship.

### 3 4 DECISION-MAKING CAPACITY, AUTONOMY & FUTURE SELVES

5  
6 Concepts of decision-making capacity and autonomy are central to the process of advance care  
7 planning and the use of both medical and psychiatric advance directives. But while they pose  
8 fundamentally similar challenges in both contexts, there are important nuances.

9  
10 The process of advance care planning and use of advance directives is intended to guide treatment  
11 for patients should they become unable to make care decisions themselves. To participate  
12 meaningfully in the process of advance care planning and to execute a valid advance directive,  
13 patients must have decision-making capacity. That is, the patient must be able to understand and  
14 reason about future treatment choices and to articulate preferences for future care in light of their  
15 values, goals, and life experiences, including prior health care experiences.

16  
17 Decision-making capacity also plays a role in determining when an advance directive will govern  
18 treatment decisions. Directives take effect when the patient has lost decision-making capacity and  
19 is not able to make or express contemporaneous choices among treatment options. Decision-  
20 making capacity in the moment is assessed relative to the specific decision to be made—a patient  
21 may have capacity to make some decisions, but not others. Moreover, capacity can fluctuate over  
22 the course of an illness or episode of care. While for patients, for example, those who have  
23 experienced extensive brain damage for whom there is no reasonable expectation of regaining  
24 cognitive function, physicians can make a global assessment; for others, capacity must be assessed  
25 over time and in relation to the decision at hand.

26  
27 For patients with mental health conditions, the question of capacity can be particularly challenging,  
28 since mental function itself is affected by psychiatric illness [6]. The baseline function of a  
29 psychiatric patient may or may not be similar to that of a patient who does not have a psychiatric  
30 illness. In addition, mental disorders often include impairment of certain isolated functions, while  
31 other functions are unaffected [6]. Assessing change in a psychiatric patient's decision-making  
32 capacity relative to their individual baseline may be difficult, especially when patient and physician  
33 have no previous relationship. Loss of capacity for a patient with a psychiatric illness may be both  
34 "less obvious and more likely to reflect a socially constructed understanding of good decision  
35 making" [6].

36  
37 In cases where decision-making capacity may fluctuate, such as bipolar disorder—whether  
38 "objectively" or merely from the perspective of the patient—there is evidence that patients support  
39 advance directives out of fear that in the future they may be in mental states where their thinking is  
40 distorted [7]. Offering such patients this option may ameliorate those fears somewhat, though this  
41 does give privileged control to the prior self that is making the decision at a given time.

42  
43 Advance directives are intended to be binding when a patient loses decision-making capacity. The  
44 use of such directives as a tool to promote patient autonomy presumes that a patient's future  
45 incapacitated self will agree with the choices made by their earlier self. Unfortunately, we know  
46 that people do not always accurately predict their future reactions in a given situation. Dresser  
47 notes that, "a growing body of research reveals that these sorts of mistakes occur whenever people  
48 make choices about what would be good and bad for them in the future. Empirical data suggest that  
49 people generally underestimate the extent to which their preferences and values will change in the  
50 future. People also tend to predict that 'bad events will be worse than they turn out to be'" [8], and



that preferences may change over time. Patients may turn out to be more accepting of outcomes they previously shunned or find burdens more onerous or insupportable than they once anticipated.

By definition, advance directives favor the autonomy of a prior self over the current self. However, whether the prior expression of a patient's autonomy should always prevail remains a debated question. As Dresser observes, such "precedent autonomy" is an important, but not the *only* consideration in making treatment choices for patients who cannot participate in the process themselves [9].

The question may become particularly acute in the context of psychiatric illness. To what extent is the self who is suffering from a psychiatric relapse or crisis truly autonomous, even when the individual communicates coherently? There can be considerable benefit in adhering to preferences stated by the mentally stable self, which were intended precisely to address circumstances of relapse or crisis. By executing a PAD, the patient obligates themselves to what proponents have called a Ulysses contract: "just as [Ulysses] instructed his crew to bind him to the mast before they sailed past the irresistible Sirens and to ignore his requests for release, such patients should be able to contract with their physicians to disregard certain specified instructions they might issue during relapse (such as refusing needed treatment) for a limited period of time" [10].

#### RELEVANT AMA POLICY

Currently, the AMA does not have specific policy regarding psychiatric advance directives. However, AMA policy is strongly supportive of the philosophy, goals, and use of advance directives in general. Guidance in the *AMA Code of Medical Ethics* in Opinions 5.1, "[Advance Care Planning](#)," particularly underscores the ethical values of patient autonomy and self-determination and sets out physicians' responsibilities to encourage and assist advance care planning. Opinion 5.2, "[Advance Directives](#)," addresses the conditions for sound application of advance directives in making clinical decisions for patients who lack capacity.

House policies similarly support advance directives and encourage their use:

- H-140.845, "[Encouraging the Use of Advance Directives and Health Care Powers of Attorney](#)"
- H-85.956, "[Educating Physicians About Advance Care Planning](#)"
- H-85.957, "[Encouraging Standardized Advance Directives Forms within States](#)"
- H-85.952, "[Advance Directives During Pregnancy](#)"

#### STATE LAW

Nearly every state in the U.S. allows for PAD in some form [2], either directly in statutes that specifically permit PADs, or indirectly in advance directive laws that allow directives that address mental health care [11-21].

Particularly noteworthy is Virginia, which is the "first state to purposefully commit itself to systematically incorporating psychiatric advance directives into routine mental health care practice" [1]. Virginia's "Health Care Decisions Act" authorizes advance directives for all medical decisions and allows patients to give instructions on "any aspect" of their psychiatric care. A PAD takes effect under the law when the treating physician and a second independent physician or clinical psychologist determine that the patient has lost decision-making capacity [22-24]. Nevada and New Hampshire, in contrast, do not permit free-standing directives explicitly for psychiatric care, but do allow patients to appoint a Durable Power of Attorney for Health Care and encourage patients to convey their specific wishes regarding psychiatric treatment to their health care agent [25,26].

1 A majority of state statutes allow mental health providers “to petition a court to have a PAD  
2 overridden when the patient’s PAD runs contrary to the patient’s best interest” [2]. However, in  
3 *Hargrave v. Vermont* the U.S. 2<sup>nd</sup> Circuit Court of Appeals found “legal precedent precluding the  
4 ability to override a patient’s expressed preferences in a PAD” [2]. While this precedent is not  
5 binding nationally, it holds persuasive influence and “could be cited in a challenge to any PAD  
6 statutes that allow for overriding stated preferences that are not consistent with standard of care or  
7 safety needs” [2].

## 8 9 CONCLUSION

10  
11 Advance care planning and the use of advance directives can help support shared decision making  
12 and promote patient autonomy and interests. In the context of psychiatric care, whether patients  
13 benefit more from engaging with physicians in the planning process or from the implementation of  
14 directives in episodes of relapse or crisis offers opportunity for further study. The deeper question  
15 under what conditions the “precedent autonomy” reflected in a PAD should prevail over the  
16 patient’s contemporaneously expressed wishes remains a matter of philosophical debate.

## 17 18 RECOMMENDATION

19  
20 Your Board of Trustees recommends that the following be adopted in lieu of Resolution 1-I-19 and  
21 the remainder of this report be filed:

22  
23 That our AMA:

- 24
- 25 1. Recognizes the potential for advance care planning to promote the autonomy of patients with  
26 mental illness; (New HOD Policy) and
  - 27 2. Urges the mental health community to continue to study the role of advance care planning in  
28 therapeutic relationships and the use of psychiatric advance directives to promote the interests  
29 and well-being of patients. (New HOD Policy)
- 30

Fiscal note: Less than \$500

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## REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-22

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers,  
Policy H-420.954 (Resolution 8-N-21)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Resolution 8-N-21, “Amendment to Truth and Transparency in Pregnancy Counseling Centers,  
2 H-420.954,” submitted by the Medical Student Section, calls on our AMA to amend existing policy  
3 “to further strengthen our AMA policy against the dissemination of purposely incomplete or  
4 deceptive information intended to mislead patients and the utilization of state and federal funds for  
5 potentially biased services provided by pregnancy counseling centers,” as follows:

6  
7 H-420.954, Truth and Transparency in Pregnancy Counseling Centers

8  
9 1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose  
10 information on site, in its advertising; and before any services are provided concerning medical  
11 services, contraception, termination of pregnancy or referral for such services, adoption options  
12 or referral for such services that it does and does not provides, as well as fully disclose any  
13 financial, political, or religious associations which such entities may have;

14  
15 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical,  
16 emotional, or financial means) by any agency offering crisis pregnancy services that aim to  
17 discourage or interfere with a pregnant woman’s pursuit of any medical services for the care of  
18 her unplanned pregnancy;

19  
20 3. Our AMA advocates that any entity providing medical or health services to pregnant women  
21 that markets medical or any clinical services abide by licensing and have the appropriate  
22 qualified licensed personnel to do so and abide by federal health information privacy laws, and  
23 additionally disclose their level of compliance to such requirements and laws to patients  
24 receiving services;

25  
26 4. Our AMA opposes the utilization of state and federal funding to finance such entities  
27 offering crisis pregnancy services, which do not provide statistically validated evidence-based  
28 medical information and care to pregnant women.

29  
30 Testimony at the November 2021 Special Meeting of the House of Delegates generally supported  
31 the intent of the resolution, noting the predatory actions taken by many nonclinical pregnancy  
32 counseling centers. However, testimony also expressed concern with the specific amendments as  
33 proposed, including concern about the feasibility of monitoring or enforcing compliance with  
34 disclosure requirements.

## BACKGROUND

On the best current estimate, there are nearly 5,000 pregnancy counseling centers (also known as “crisis pregnancy centers” and “limited services pregnancy centers”) in the U.S. that provide health-related services and counseling to women who are or believe they may be pregnant, with the goal of dissuading women from seeking or receiving abortion [1,2]. Opposition to abortion is legally permitted and ethically recognized, and such centers do offer benefit to their clients, including social and other support, for those who choose to continue their pregnancies. Because pregnancy counseling centers do not charge for their services, they may be particularly attractive to women who otherwise have limited or no access to clinical care.

However, centers are also known to mislead prospective clients, implying that they offer or provide referral for abortion or contraceptive services [3], and to engage in practices that inhibit timely decision making for pregnant women who are seeking abortion [1,2,3]. Although increasingly such centers employ licensed medical personnel and are recognized as licensed medical facilities [1], the majority are not subject to regulatory oversight [3].

Since the 1980s, there have been multiple legal efforts to curb centers’ false or misleading advertising of their services and their misleading presentation of medical information [1,2,3]. Most recently Connecticut enacted [Public Act No. 21-17](#), “Act Concerning Deceptive Advertising Practices of Limited Services Pregnancy Centers,” which went into effect in July 2021. The act prohibits centers from making “any statement concerning any pregnancy-related service or the provision of any pregnancy-related service that is deceptive, whether by statement or omission” that the center “knows or reasonably should know to be deceptive.” Whether the law will survive possible legal challenge or prove effective remains to be seen.

California’s Reproductive FACT (Freedom, Accountability, Comprehensive Care, and Transparency) Act, passed in 2015, called for clinics to provide specific disclosures regarding services. Medically licensed centers would have been required to post specific notice that public programs “provide immediate free or low-cost access to comprehensive family planning services ... prenatal care, and abortion for eligible women,” with the telephone number for county social services. Unlicensed centers would have been required to post notice that the center was “not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services” [1]. The act was immediately challenged on grounds of free speech and free exercise of religion but was upheld by district courts and the U.S. Court of Appeals for the Ninth Circuit. However, in June 2018 the U.S. Supreme Court reversed the Ninth Circuit and “remanded the case for further proceedings consistent with the conclusion that the free speech challenge was likely to succeed” [1].

## POLICIES OF PROFESSIONAL MEDICAL ORGANIZATIONS

In 2019, the Society for Adolescent Health and Medicine (SAHM) and the North American Society for Pediatric and Adolescent Gynecology (NASPAG) published a joint position statement opposing crisis pregnancy centers. The statement encourages government entities “to only support programs that provide .... medically accurate, unbiased, and complete health care information,” including information about FDA-approved contraceptives and “the full range of pregnancy options” [4]. The statement further urges regulatory and accrediting bodies to ensure that health care professionals and services provided at crisis pregnancy centers “adhere to established standards of care,” as well as discouraging school boards from “outsourcing sexuality education” to such centers and urging companies that own digital platforms and search engines to monitor how centers represent their services and taking steps to prevent misrepresentation [4].

The American College of Obstetricians and Gynecologists (ACOG) opposes legislative, financial, and other barriers that restrict access to abortion, including the “nonlegislative” barrier posed by crisis pregnancy centers [5]. ACOG has criticized crisis pregnancy centers for providing inaccurate medical information linking abortion with breast cancer, infertility, and mental health on Twitter (#FactsAreImportant, September 3, 2020).

#### AMENDING POLICY H-420.954

Given the failure of efforts to regulate crisis pregnancy centers, and the fact that the Supreme Court’s 2018 decision suggests notifications of the sort proposed by California would likely amount to “compelled speech impermissible under the First Amendment” [1], it is not clear that amending H-420.954 as Resolution 8-N-21 urges would materially strengthen policy or enhance AMA’s ability to oppose crisis pregnancy centers in further legal action. The more prescriptive the policy statement, the less room for action it may offer.

Nonetheless, it is not unreasonable to argue that any entity that represents itself as offering health-related services or counseling, including crisis pregnancy centers, should be expected to adhere to standards of truthfulness and transparency expected of licensed health care facilities and licensed personnel. Many policies of the House of Delegates touch on issues of truth in advertising analogous to those posed by crisis pregnancy centers. Most closely related is Policy [H-150.946](#), “Herbal Supplements,” which holds that “that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products.”

Other policies similarly touch on the fundamental issue of truthful representation, including:

- [H-160.921](#), “Retail Clinics”
- [H-175.992](#), Deceptive Health Care Advertising
- [H-180.945](#), Health Plans’ Medical Advice
- [H-225.994](#), Hospital Advertising in Printed and Broadcast Media
- [H-270.982](#), Truth in Advertising Standards for Managed Health Care Plans
- [H-405.968](#), Clarification of the Term “Provider” in Advertising, Contracts, and other Communication
- [E-9.6.1](#), Advertising and Publicity
- [E-9.6.7](#), Direct-to-Consumer Advertising of Prescription Drugs and Medical Devices
- [E-9.6.8](#), Direct-to-Consumer Diagnostic Imaging Tests

Still further policies address truth and advertising with respect to nonclinical products, e.g.:

- [H-495.981](#), Light and Low-Tar Cigarettes
- [H-495.985](#), Smokeless Tobacco

AMA likewise has strong policy on the obligation to provide scientifically accurate information and support informed decision making, including:

- [E-8.12](#), Ethical Physician Conduct in the Media
- [H-140.989](#), Informed Consent and Decision-Making in Health Care
- [E-2.1.1](#), Informed Consent
- [E-2.1.3](#), Withholding Information from Patients

Taken together, existing AMA policies provide ample foundation to argue for oversight of crisis pregnancy centers. Moreover, the recent SAHM-NASPAG position statement discussed above

1 offers more circumspect language than that proposed by Resolution 8-N-21. That is, to focus on  
2 what oversight bodies can and should do rather than dictate specific practice to crisis pregnancy  
3 centers.

4  
5 RECOMMENDATION

6  
7 For the reasons discussed above, your Board of Trustees recommends that Policy H-420.954 be  
8 amended by insertion and deletion to read as follows in lieu of Resolution 8-N-21 and that the  
9 remainder of this report be filed:

10  
11 H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”

- 12  
13 1. It is AMA’s position that any entity that represents itself as offering health-related services  
14 should uphold the standards of truthfulness, transparency, and confidentiality that govern  
15 health care professionals.  
16  
17 2. Our AMA urges the development of effective oversight for entities offering pregnancy-  
18 related health services and counseling.  
19  
20 3. ~~Our AMA supports advocates~~ that any entity offering crisis pregnancy services  
21 ~~disclose information~~  
22  
23 a. truthfully describe the services they offer or for which they refer—including prenatal  
24 care, family planning, termination, or adoption services—in communications on site,  
25 and in its their advertising, and before any services are provided to an individual  
26 patient; and concerning medical services, contraception, termination of pregnancy or  
27 referral for such services, adoption options or referral for such services that it provides,  
28  
29 b. be transparent with respect to their funding and sponsorship relationships.  
30  
31 4. Our AMA advocates that any entity licensed to provide ~~providing~~ medical or health services  
32 to pregnant women ~~that markets medical or any clinical services abide by licensing and~~  
33 ~~have the~~  
34  
35 a. ensure that care is provided by appropriately qualified, licensed personnel; ~~to do so and~~  
36  
37 b. abide by federal health information privacy laws.  
38  
39 5. Our AMA urges that public funding only support programs that provide complete,  
40 medically accurate, health information to support patients’ informed, voluntary decisions.  
41 (Modify Current HOD Policy)

Fiscal note: less than \$500.

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## REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-22

Subject: Opposition to Requirements for Gender-Based Treatments for Athletes  
(Resolution 19-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Resolution 19-A-19, “Opposition to Requirements for Gender-Based Treatment for Athletes,”  
2 sponsored by the Medical Student Section, was referred to the Board of Trustees. The resolution  
3 asked:

- 4  
5 1. That our American Medical Association (AMA) oppose any regulations requiring  
6 mandatory medical treatment or surgery for athletes with Differences of Sex Development  
7 (DSD) to be allowed to compete in alignment with their identity; and  
8
- 9 2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender  
10 classification for athletic competitions.  
11

### 12 BACKGROUND

13  
14 Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics  
15 Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with  
16 differences of sex development (DSD) who wish to compete as women in certain international  
17 track and field events. Under these guidelines, to be eligible to compete in the 400 meters, hurdles  
18 races, 800m, 1500m, one-mile races and combined events over the same distances, women with  
19 DSD who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- 20  
21 • be legally recognized as female or intersex
- 22 • reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous  
23 period of 6 months, and
- 24 • maintain their serum testosterone level below 5 nmol/L continuously for as long as they  
25 wish to remain eligible to compete (regardless of whether they are in competition) [1]  
26

27 Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible  
28 to compete in all events that are not international competitions and in events in international  
29 competitions other than those specifically prohibited [1].  
30

31 These guidelines represent the most recent in a series of efforts by the international athletic  
32 community to ensure fairness in women’s competitions that began with “gender verification”  
33 policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press,  
34 who were suspected of being male, in the 1960 and 1964 Olympics, female athletes were required  
35 to prove their sex to be eligible to compete as women in international events [2].

1 Over time, procedures to determine sex evolved from having female athletes parade naked before a  
2 panel of judges, through gynecological examination of external genitalia, to the use of sex  
3 chromatin tests, and ultimately DNA-based testing [2]. In 2000, the International Olympic  
4 Committee (IOC) and IAAF discontinued routine gender verification in favor of “suspicion-based  
5 testing,” reserving the right to test if officials or competitors raised questions about a female  
6 athlete’s sex.

7  
8 In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC’s Medical  
9 Commission recommended hormone-based testing, that is, that individuals recognized in law as  
10 female be eligible to compete in women’s competitions so long as their serum testosterone levels  
11 were “below the male range” or if they had an androgen resistance and derived no competitive  
12 advantage from testosterone levels in the male range [2]. The IAAF adopted hormonal testing and  
13 implemented new policy that routinely tested all female athletes and required those who tested  
14 outside the normal range to undergo treatment to normalize their androgen levels to be eligible to  
15 compete.

16  
17 In March 2019 the United Nations Council on Human Rights adopted Resolution 40/5,  
18 “Elimination of discrimination against women and girls in sport,” noting concern that the  
19 IAAF/World Athletics eligibility criteria

20  
21 are not compatible with international human rights norms and standards, including the rights of  
22 women with differences of sex development, and concerned at the absence of legitimate and  
23 justifiable evidence for the regulations to the extent that they may not be reasonable and  
24 objective, and that there is no clear relationship of proportionality between the aim of the  
25 regulations and the proposed measures and their impact [3].

26  
27 The resolution further expressed concern that

28  
29 discriminatory regulations, rules and practices that may require women and girl athletes with  
30 differences of sex development, androgen sensitivity and levels of testosterone to medically  
31 reduce their blood testosterone levels contravene international human rights norms and  
32 standards ... [3]

33  
34 In 2021, following ongoing controversy, the IOC amended its stance and issued a new “Framework  
35 on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations”  
36 that eliminated specific instructions on eligibility to compete [4]. Rather, the framework sought to  
37 offer general guidance to sports governing bodies

38  
39 to promote a safe and welcoming environment for everyone, consistent with the principles  
40 enshrined in the Olympic Charter,” and “acknowledges the central role that eligibility criteria  
41 play in ensuring fairness, particularly in high-level organized sport in the women’s category”  
42 [4].

43  
44 With the framework, the IOC recognized “that it is not in a position to issue regulations that define  
45 eligibility for every sport” and explicitly left it “to each sport and its governing body to determine  
46 how an athlete may be at disproportionate advantage to their peers” [4].

47  
48 Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its  
49 eligibility criteria published a correction in response to ongoing critique from independent  
50 statisticians. The correction acknowledged that “there is no confirmatory evidence for causality in  
51 the observed relationships reported” [5]. The authors further noted that the initial research was

1 “exploratory and not intend[ed] to prove a causal influence” and that “some statements in the  
2 original publication “could have been misleading” [5].

3  
4 World Athletics has not modified its criteria [5], however, and controversy regarding participation  
5 by female athletes with DSD continues.<sup>1</sup>

## 6 7 FAIRNESS IN SPORT

8  
9 Regulations intended to promote fairness in sport by restricting the participation of individuals  
10 whose genetic characteristics are deemed to give them unfair advantage over competitors raise a  
11 series of questions about what the goals of sport are, what counts as an “unfair” advantage, and  
12 what should be done to “level the playing field.”

### 13 14 *Biological Advantage*

15  
16 Policy restricting competition by female athletes who have serum testosterone levels above a  
17 designated “normal” range rests on (at least) two problematic assumptions. The first of those  
18 assumptions is that there is a straightforward relationship between testosterone and athletic  
19 performance that unequivocally gives these athletes significant advantage over female competitors  
20 whose bodies do not produce “excess” endogenous testosterone. The second is that serum  
21 testosterone levels can meaningfully be measured, and that prescribed levels can be safely and  
22 effectively maintained. The specific contribution of testosterone to overall athletic performance  
23 continues to be a subject of debate. Notably, critics of the research on which the IAAF based its  
24 regulations on endogenous testosterone have argued that a key study concluding that women with  
25 the highest testosterone levels significantly and consistently outperformed other female competitors  
26 rests on flawed data [6]. Concerns have also been raised about the rigor of its statistical analysis  
27 [7]. The main author, moreover, was the director for the IAAF Science and Health Department,  
28 raising questions about possible conflict of interest [8]. More important, however, demonstrating a  
29 correlation between testosterone and athletic performance in female athletes falls short of  
30 establishing the unfairness of such advantage [8].

31  
32 However, even if the effect of testosterone on athletic performance was conclusively established  
33 specific to the restricted events identified by the IAAF, single point-in-time tests for overall level  
34 of serum testosterone cannot provide conclusive evidence that the individual has or will benefit. It  
35 is known that women with androgen insensitivity disorder physiologically cannot gain benefit from  
36 excess endogenous testosterone. Multiple factors affect serum concentrations of testosterone,  
37 including time of day; age- and gender-corrected normal ranges using a standard assay have not  
38 been established; and there is no universally recognized standard for calibrating testosterone [9].

39  
40 Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the  
41 “bio-testosterone”) is not well understood” [10]. Nor do the IAAF regulations take into account the  
42 existing lack of consensus about “how to use medications safely to lower testosterone levels when  
43 used off-label, the side effects of the medications, [or] the difficulties of maintaining the  
44 testosterone levels below the levels requested by IAAF owing to natural fluctuations” [8].

---

<sup>1</sup> Analogous controversy continues with respect to sports participation by transgender women at all levels of competition. For an exploration of issues in this context in relation to the IOC framework, see Harper J. Transgender athletics and international sports policy. *Law and Contemporary Problems* 2022;85:151-165. Available at <https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5035&context=lcp>. Accessed March 23, 2022.

## 1 *Leveling the Playing Field*

2  
3 Assuming, for purposes of analysis, that testosterone does confer a significant competitive  
4 advantage in sport, knowing that does not in itself determine what steps should be taken to “level  
5 the playing field.” The latter decision is a normative matter, not an empirical one.  
6

7 To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair  
8 advantage over competitors require that rules treat all relevantly similar advantage-conferring  
9 attributes in a like manner for all prospective competitors. Testosterone testing for female athletes  
10 who have been singled out on the basis of their appearance or performance for all practical  
11 purposes subjects these individuals to genetic testing not imposed on their competitors.  
12

13 Fairness would thus require that sports organizations test for any “performance enhancing genes  
14 that predispose [individual athletes] to be athletically superior” [11]. In the present state of  
15 knowledge, this is no more realistic an approach than are current testosterone assays. The influence  
16 of genetic factors on athletic performance is multifactorial and sport specific [12]. Organizations  
17 would further have to regulate all such advantage-conferring attributes consistently.  
18

19 One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable or  
20 dynamic [13]. Fair advantages are those the athlete largely cannot affect (such as chronological  
21 age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as speed,  
22 strength, endurance, etc.). On this account, genetic differences in testosterone would be stable  
23 advantages that could be subject to leveling or more fine-grained classification.  
24

25 Thinking specifically about leveling the playing field with respect to genetically based inequalities  
26 in endogenous testosterone, three approaches present themselves [8]. First, sports organizations  
27 could require athletes to lower testosterone levels that exceed a defined threshold. Sports  
28 organizations could require that athletes with testosterone levels that exceed a defined threshold  
29 lower them to below a predetermined level.  
30

31 As a second approach, organizations could create separate categories for competition based on the  
32 level of biological variations, allowing all athletes with serum testosterone within a certain range to  
33 compete against one another, regardless of sex or gender identification [8]. Or, third, they could  
34 create categories based on modifying the external conditions of competition instead of intervening  
35 in athletes’ bodies. Handicapped horse racing offers a model [8].  
36

## 37 THE ROLE OF PHYSICIANS

38  
39 World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of  
40 athletes. In doing so, they virtually require the participation of physicians helping athletes achieve  
41 and maintain the stipulated levels of serum testosterone. To the extent that medical interventions to  
42 lower testosterone are not *clinically* indicated, is physician participation appropriate? Overall,  
43 existing policies of the American Medical Association and the World Medical Association (WMA)  
44 argue against physicians implementing these regulations.  
45

46 Existing AMA policy in H-470.978, “[Blood Doping](#),” and H-470.976, “[Abuse of Anabolic](#)  
47 [Steroids](#),” prohibit physician participation in blood doping or prescribing anabolic steroids.  
48 H-470.994, “[Non-Therapeutic Use of Pharmacological Agents by Athletes](#),” opposes the use of  
49 interventions to enhance athletic performance but is silent with respect to physicians’ specific  
50 responsibilities.

1 [Principle VIII](#) of the AMA *Principles of Medical Ethics* states that “A physician shall, while caring  
2 for a patient, regard responsibility to the patient as paramount.” Opinion 1.2.5, “[Sports Medicine](#),”  
3 in the AMA *Code of Medical Ethics* limits its focus to physicians present during athletic events. It  
4 directs those who “serve in a medical capacity at athletic, sporting, or other physically demanding  
5 events should protect the health and safety of participants.” Opinion 5.5, “[Medically Ineffective](#)  
6 [Interventions](#),” which specifically addresses the use of life-sustaining interventions in contexts of  
7 terminal illness, provides that physicians “should only recommend and provide interventions that  
8 are medically appropriate.” It notes further that patients should not receive specific interventions  
9 simply because they request them.

10  
11 In a press release in April 2019, the [World Medical Association](#) demanded that the IAAF  
12 “immediately withdraw” its new eligibility regulations for classifying female athletes and urged  
13 physicians to “take no part” in implementing them. In October 2021 WMA updated “[Declaration](#)  
14 [on Principles of Health Care in Sports Medicine](#)” to oppose World Athletics eligibility regulations  
15 and condemn “medical treatment solely to alter athletic performance,” as “unethical.”

16  
17 These provide several strong arguments, that, as professionals committed to promoting first and  
18 foremost the well-being of their patients, it is not appropriate for physicians to provide medical  
19 interventions for athletes required to fulfill the World Athletics regulations on endogenous  
20 testosterone for female athletes with differences of sexual development.

## 21 22 RECOMMENDATION

23  
24 In view of these considerations, your Board of Trustees recommends that the following  
25 recommendations be adopted in lieu of Resolution 19-A-19 and the remainder of this report be  
26 filed:

- 27  
28 1. That our American Medical Association (AMA) oppose mandatory medical treatment or  
29 surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in  
30 alignment with their identity; (New HOD Policy)
- 31  
32 2. That our AMA oppose use of specific hormonal guidelines to determine gender classification  
33 for athletic competitions. (New HOD Policy)

Fiscal note: Less than \$500.

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# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-22

Subject: Clarification to the Bylaws: Delegate Representation

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Annual Meeting, the House referred CCB Report 1, “Clarifications to the Bylaws – Delegate Representation, Registration and Credentialing,” to the Council for report back. At the 2019 meeting, the House adopted two Council reports that included elements of referred CCB Report 1-A-19. This third report focuses on the general issue of representation in our AMA House of Delegates (HOD), with clarifying language regarding the medical student regional delegates and the delegates from the Resident and Fellow Section.

## DELEGATE REPRESENTATION

Our AMA HOD, per Article IV of the AMA Constitution, is the legislative and policymaking body of the Association. Article III establishes that the AMA is comprised of individual members who are represented through constituent associations, national medical specialty societies and other entities, as specified in the Bylaws. Since delegates and alternate delegates can only achieve HOD representation via one of the aforementioned entities, which includes the sections, the Council opines that an underlying premise of the various AMA bylaws is that a delegate can only represent an organization of which he/she is a member. Bylaw 2.0.1.2 speaks to the multi-dimensional role of delegates, including representation of the perspectives of the delegate’s sponsoring organization, and Bylaw 2.10.3, “Lack of Credentials” alludes to the need for “proper identification as the delegate or alternate delegate selected by the respective organization.”

There was limited discussion of the Council’s recommendation in CCB Report 1-A-19 mandating delegate membership in the entity one is representing. Thus, the Council reintroduces amendments to address the representation requirement of delegates to our AMA House of Delegates.

Other more controversial issues touching on regional medical student representation and RFS sectional delegates from CCB 1-A-19 are discussed below.

## REGIONAL MEDICAL STUDENT REPRESENTATION

Similar to the other AMA sections, the Medical Student Section (MSS) elects a delegate and an alternate delegate. In addition, there are medical student regional delegates and alternate delegates. There are seven medical student regions defined for the purposes of electing regional delegates to the AMA House of Delegates. Per Bylaw 2.3.2, each medical student region, as defined by the Medical Student Section, is entitled to “one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the medical student region.” The regions are as follows:

1       Region 1: Washington, Oregon, California, Nevada, Utah, Colorado, Arizona, New Mexico,  
2             Montana, North Dakota, South Dakota, Idaho, Wyoming, Alaska, Hawaii.  
3       Region 2: Minnesota, Wisconsin, Nebraska, Iowa, Missouri, Illinois.  
4       Region 3: Kansas, Texas, Oklahoma, Arkansas, Louisiana, Mississippi.  
5       Region 4: Florida, Georgia, Alabama, South Carolina, North Carolina, Tennessee, Puerto Rico.  
6       Region 5: Michigan, Indiana, Ohio, Kentucky, West Virginia.  
7       Region 6: Virginia, Maryland, District of Columbia, Delaware, New Jersey, Pennsylvania.  
8       Region 7: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New  
9             York.

10  
11       Per Bylaw 2.3.3, “Each elected medical student section delegate must receive written endorsement  
12       from the constituent association representing the jurisdiction within which the medical student’s  
13       educational program is located, in accordance with procedures adopted by the MSS and approved  
14       by the Board of Trustees.” The medical student regional delegate and alternate delegate positions  
15       are typically funded by the endorsing constituent association, although there is no requirement to  
16       do so. Each regional medical student delegate is seated with his/her endorsing constituent  
17       association, again per AMA bylaws, with any student who subsequently substitutes for that  
18       regional medical student delegate seated with that same constituent association.

19  
20       At the A-19 Reference Committee on Amendments to Constitution and Bylaws, there was  
21       divergent testimony as to what entity a medical student regional delegate represents in the House of  
22       Delegates. A candidate standing for election to a medical student regional delegate or alternate  
23       delegate position must be endorsed by a constituent association; at the MSS meeting, medical  
24       students from the same region vote to elect one or more candidates from the region. Yet a medical  
25       student regional delegate has some obligation to the constituent association that endorsed their  
26       candidacy and that often funds their participation. The Council acknowledges that the medical  
27       student regional delegates to the House of Delegates have competing loyalties to their endorsing  
28       constituent association, the MSS, their medical student region and their educational program, and  
29       that the positions of each may differ on important items of business. Furthermore, AMA Bylaw  
30       2.0.1.2. acknowledges this multi-dimensional role of all AMA delegates. The Council, however,  
31       continues to believe that membership in the endorsing constituent association is essential for any  
32       medical student regional delegate and thus should be articulated in our AMA Bylaws.

33  
34       In proposing amendments to Bylaw 2.3, the Council has included language that parallels that in the  
35       Medical Student Section’s Internal Operating Procedures approved by the Board of Trustees to  
36       address the qualifications of the medical student regional delegate and the regional delegate  
37       substitution process. The Council believes that the House of Delegates, endorsing constituent  
38       associations, and AMA delegations should be familiar with the Board-approved process when there  
39       are vacancies. Again, the Council stands by its language regarding membership in the endorsing  
40       constituent association for the medical student regional delegates and alternate delegates.

41  
42       The Council also has expanded existing bylaw language in 2.10.8 to provide clarity regarding the  
43       seating of substitute medical student regional delegates in the House of Delegates. The new  
44       language is consistent with current practice as approved by the Board and addressed in the Internal  
45       Operating Procedures.

46  
47       Lastly, the Council also heard some concerns in 2019 from medical students who train full time in  
48       a state different than the state where their educational program is located. The Council has learned  
49       that the Medical Student Section is seeking to revise the language in its Internal Operating  
50       Procedures that speaks to this issue specifically as well as other issues associated with multiple  
51       medical student campuses, so in this report the Council also is proposing amendments to Bylaws



2.3.3 and 2.10.8 to eliminate language referring to the jurisdiction of the medical student's educational program.

#### RFS REPRESENTATION

Similar to other AMA Sections, the Resident and Fellow Section (RFS) has a single delegate and alternate delegate. Additional RFS delegates and alternate delegates to the House of Delegates are elected at the RFS Assembly meeting based on the apportionment of one delegate for every 2,000 active resident and fellow members of the AMA. These sectional RFS delegates must be endorsed by a constituent association, a national medical specialty society, a professional interest association, or a federal service. These positions are typically funded by the endorsing association, society, or federal service and each RFS delegate is seated with the endorsing entity per AMA bylaws, with any resident who substitutes for an RFS delegate being seated with that same entity.

AMA Bylaw 2.0.1.2.1 states "In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their physician constituents." Most delegations caucus prior to and during the House meeting and develop a delegation position on pending items of business. The Council acknowledges that the sectional RFS delegates, like the medical student regional delegates, have competing loyalties as they represent not only their endorsing/sponsoring/funding entity but the RFS in the House of Delegates, and that the positions of the sponsoring entity and the AMA section may differ on important items of business. As with the medical student regional delegates, the Council believes that membership in the endorsing entity is essential for the sectional RFS delegates and alternate delegates and thus should be articulated in our AMA Bylaws.

The Council notes that RFS delegate substitutions are more flexible as these individuals are elected at-large and not regionally as are the regional medical student delegates or even by specialty. The RFS procedures adopted by the RFS Assembly and the Board of Trustees state that "Sectional Delegate vacancies shall be filled by a temporary appointment from the available Sectional Alternate Delegates at the discretion of the RFS Delegate and Alternate Delegate. Sectional Alternate Delegate vacancies shall be filled by a temporary appointment of RFS members present at the current House of Delegates meeting at the discretion of the RFS Delegate and Alternate Delegate... Consideration in temporary appointments shall be given to members who maintain or increase diversity of RFS representation in the House of Delegates with regards to sponsoring state and specialty societies."

The Council has proposed changes to several bylaws to clarify that AMA membership and membership in the endorsing entity is required of each RFS sectional delegate and alternate delegate. RFS delegates may be endorsed by entities represented in the AMA House of Delegates other than constituent associations or national medical specialty societies, namely professional interest medical associations or federal services, a practice allowed under procedures adopted by the RFS Assembly and approved by the Board of Trustees.

The Council has also expanded the language in Bylaw 2.10.9 to address the seating of substitute RFS delegates in the House of Delegates.

RECOMMENDATIONS

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

**2.0.1 Composition and Representation.** The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

**2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of Delegates must be active members of the AMA and of the entity they represent.

**2.8 Alternate Delegates.** Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

**2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of the entity they represent.

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**2.3 Medical Student Regional Delegates.** In addition to the delegate and alternate delegate representing the Medical Student Section, ~~regional~~ medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

**2.3.1 Qualifications.** Medical ~~S~~student ~~R~~regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of their endorsing constituent association. The region in which the endorsing society is located determines the student's region, and a medical student may serve as a regional delegate, alternate delegate or any form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only for that region.

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**2.3.3** Medical ~~S~~student ~~R~~regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate delegate must receive written endorsement from ~~the~~ their constituent association ~~representing the jurisdiction within which the medical student's educational program is located,~~ in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the next Annual Meeting of the House of Delegates.

**2.4 Delegates from the Resident and Fellow Section.** In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

1       **2.4.1 Qualifications.** Delegates and alternate delegates from the Resident and Fellow  
2       Section must be active members of the Resident and Fellow Section of the AMA.  
3       In addition, resident and fellow physician delegates and alternate delegates must be  
4       members of their endorsing society or organization currently seated in the HOD.  
5

6       **2.4.2 Apportionment.** The apportionment of delegates from the Resident and Fellow  
7       Section is one delegate for each 2,000 active resident and fellow physician  
8       members of the AMA, as recorded by the AMA on December 31 of each year.  
9

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11

12       **2.4.3 Election.** Delegates and alternate delegates shall be elected by the Resident and  
13       Fellow Section in accordance with procedures adopted by the Section. Each  
14       delegate and alternate delegate must receive written endorsement from ~~his or her~~ a  
15       society or organization currently seated in the House of Delegates and a constituent  
16       ~~association or national medical specialty society~~, in accordance with procedures  
17       adopted by the Resident and Fellow Section and approved by the Board of  
18       Trustees.  
19

20       \*\*\*  
21

22       **2.10.8 Medical Student Seating.** Each ~~M~~medical Sstudent ~~R~~egional delegate shall be  
23       seated with the student's endorsing constituent association representing the  
24       ~~jurisdiction within which such delegate's educational program is located.~~ Alternate  
25       or substitute delegates shall be assigned to the original regional delegate's seat  
26       location during the time they are seated for the original delegate.  
27

28       **2.10.9 Resident and Fellow Seating.** Each delegate from the Resident and Fellow  
29       Section shall be seated with the physician's endorsing society or organization  
30       ~~constituent association or specialty society~~. In the case where a delegate has been  
31       endorsed by multiple entities ~~both a constituent association and specialty society~~,  
32       the delegate must choose, prior to the election, with which delegation the delegate  
33       wishes to be seated. Alternate or substitute delegates shall be assigned to the  
34       original delegate's seat location during the time they are seated for the original  
35       delegate.  
36

37  
38       (Modify Bylaws)

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

CEJA Report 1-A-22

Subject: Short-Term Medical Service Trips

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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

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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

1 have “training and/or familiarity with principles of international development, social determinants  
2 of health, and public health systems” [10].

3  
4 Adequately preparing physicians and trainees for short-term medical service trips encompasses  
5 planning with respect to issues of personal safety, vaccinations, unique personal health needs,  
6 travel, malpractice insurance, and local credentialing requirements [7]. Equally important, to  
7 contribute effectively and minimize “culture shock” and distress, volunteers need a basic  
8 understanding of the context in which they will be working [1,2,7]. Without expecting them to  
9 become experts in local culture, volunteers should have access to resources that will orient them to  
10 the language(s), traditions, norms, and expectations of the host community, not simply to the  
11 resource and clinical challenges they are likely to face. Volunteers should have sufficient  
12 knowledge to conduct themselves appropriately in the field setting, whether that is in how they  
13 dress, how they address or interact with different members of the community, or how they carry  
14 out their clinical responsibilities [7]. And they need to know whom they can turn to for guidance in  
15 the moment.

16  
17 Preparation should also include explicit attention to the possibility that volunteers will encounter  
18 ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real  
19 possibility for physicians and trainees that they will encounter situations in which they “are unable  
20 to act in ways that are consistent with ethics and their professional values” or “feel complicit in a  
21 moral wrong” [9]. Having strategies in place to address dilemmas when they arise and to debrief  
22 after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with  
23 local norms, volunteers may withdraw from care of an individual patient or from the mission after  
24 careful consideration of the effect withdrawing will have on the patient, the medical team, and the  
25 mission overall, in keeping with ethics guidance on the exercise of conscience.

### 26 27 *Choose Thoughtfully*

28  
29 Individual physicians and trainees who volunteer for short-term medical service trips are not in a  
30 position to directly influence how such programs are organized or carried out. They can, however,  
31 by preference choose to participate in activities carried out by organizations that fulfill the ethical  
32 responsibilities discussed above [9,10,11]. Volunteers can select organizations and programs that  
33 demonstrate commitment to long-term, community-led efforts to build and sustain local health care  
34 resources over programs that provide episodic, stop-gap medical interventions, which can promote  
35 dependence on the cycle of foreign charitable assistance rather than development of local  
36 infrastructure [10].

### 37 38 *Measure & Share Meaningful Outcomes*

39  
40 Organizations that sponsor short-term medical service trips have a responsibility to monitor and  
41 evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program  
42 outcomes should be appropriate to the program’s goals as defined proactively in collaboration with  
43 the host community [9]; for example, some have suggested quality-adjusted life years (QALYs)  
44 [16]. Prospective participants should affiliate themselves with programs that demonstrate  
45 effectiveness in providing outcomes meaningful to the population they serve, rather than simple  
46 measures of process such as number of procedures performed [7]. Developing meaningful outcome  
47 measures will require thoughtful reflection on the knowledge and skills needed to address the  
48 specific situation of the community or communities being served and on what preparations are  
49 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

1 careful consideration of the effect that will have on the patient, the medical team, and the  
2 mission overall, in keeping with ethics guidance on the exercise of conscience.

3  
4 Sponsors of short-term medical service trips should:

5  
6 (d) Ensure that resources needed to meet the defined goals of the trip will be in place,  
7 particularly resources that cannot be assured locally.

8  
9 (e) Proactively define appropriate roles and permissible range of practice for members of the  
10 volunteer team, including the training, experience, and oversight of team members required  
11 to provide acceptable safe, high-quality care in the host setting. Team members should  
12 practice only within the limits of their training and skills in keeping with the professional  
13 standards of the sponsor's country.

14  
15 (f) Put in place a mechanism to collect data on success in meeting collaboratively defined  
16 goals for the trip in keeping with recognized standards for the conduct of health services  
17 research and quality improvement activities in the sponsor's country.

18  
19 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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

CEJA Report 2-A-22

Subject: Amendment to Opinion 10.8, Collaborative Care

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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

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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.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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

CEJA Report 3-A-22

Subject: Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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### 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

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

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 ~~that will ensure patient safety and practice competency.~~ (II)

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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

CEJA Report 4-A-22

Subject: CEJA's Sunset Review of 2012 House Policies

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of  
2 American Medical Association policies to ensure that our AMA's policy database is current,  
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and  
4 specifying the needed procedures:  
5

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

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

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

2

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

4

5 RECOMMENDATION

6

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

Fiscal Note: Less than \$500.

## 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	The Pittsburgh Protocol: The following guidelines have been adopted:  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	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.”

		<p>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>	
<a href="#">H-370.982</a>	Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients	<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</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>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; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12)</p>	
<a href="#">H-370.983</a>	Tissue and Organ Donation	<p>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)</p>	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	Retain; remains relevant.



		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)	
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(A-22)

Introduced by: Young Physicians Section

Subject: Increasing Public Umbilical Cord Blood Donations in Transplant Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

3  
4 Whereas, Allogeneic stem cell therapy can only save lives in patients matched with a  
5 donor; and

6  
7 Whereas, Umbilical cord blood stem cells offer clinical advantages over traditional stem cell  
8 transplants in select scenarios<sup>2</sup>; and

9  
10 Whereas, Umbilical cord blood transplants increase the ethnic diversity of patients eligible for  
11 transplant<sup>3</sup>; and

12  
13 Whereas, The American Society for Transplantation and Cellular Therapy<sup>4</sup>, the American  
14 College of Obstetricians and Gynecologists<sup>5</sup>, and the American Academy of Pediatrics<sup>6</sup> all  
15 support public (altruistic) donation of cord blood when possible; and

16  
17 Whereas, Public donation of cord blood is difficult if the birthing hospital does not support public  
18 cord donation; and

19  
20 Whereas, Very few hospitals support in-house public cord blood donation infrastructure - only  
21 two hospitals in Ohio, and three each in New York and Massachusetts<sup>7</sup>; and

22  
23 Whereas, Many hospitals which provide comprehensive care including both childbirths and stem  
24 cell transplants are notably absent from these lists; therefore be it

25  
26 RESOLVED, That our American Medical Association encourage all hospitals with obstetrics  
27 programs to make available to patients and reduce barriers to public (altruistic) umbilical cord  
28 blood donation (Directive to Take Action); and be it further

29  
30 RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all  
31 states. (Directive to Take Action)

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

Received: 03/17/22

## References:

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**RELEVANT AMA POLICY**[Code of Medical Ethics. 6.1.5 Umbilical Cord Blood Banking](#)

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

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

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

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002  
(A-22)

Introduced by: New York

Subject: Opposition to Discriminatory Treatment of Haitian Asylum Seekers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The United States has sought to provide asylum for individuals being persecuted in  
2 other countries and has instituted laws and policies to achieve this goal equitably for all peoples  
3 of the world; and  
4

5 Whereas, Haitians seeking asylum have often experienced discrimination in seeking asylum  
6 because of the inaccurate media narrative of an association of AIDS to Haitians; and  
7

8 Whereas, The CDC in 1990 changed its policy on AIDS and Haitians thus removing the false  
9 narrative on AIDS and Haitians; and  
10

11 Whereas, Haitians seeking asylum in the United States continue to experience adverse  
12 outcomes in their applications for asylum based on inaccurate narratives and media bias; and  
13

14 Whereas, Recent activities at the US border with Mexico have focused heavily on denying entry  
15 to Haitians seeking escape from the violence in their native country and returning them to Haiti;  
16 and  
17

18 Whereas, Our AMA has many policy statements on health disparities, racial discrimination and  
19 equality but no policy specific to the matter adversely affecting Haitian asylum seekers;  
20 therefore be it  
21

22 RESOLVED, That our American Medical Association oppose discrimination against Haitian  
23 asylum seekers which denies them the same opportunity to attain asylum status as individuals  
24 from other nations. (New HOD Policy)

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

Received: 03/22/22

### RELEVANT AMA POLICY

#### Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(A-22)

Introduced by: Women Physicians Section

Subject: Gender Equity and Female Physician Work Patterns During the Pandemic

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Studies show that women carry more responsibility than their male counterparts for  
2 personal and family life<sup>1, 3</sup>; and  
3

4 Whereas, A study following a cohort of faculty from the 1995 National Faculty Survey through  
5 17 years showed persistent gender disparities in rank, retention, and leadership positions;<sup>2</sup> and  
6

7 Whereas, Prior to the pandemic, due to the culture of medicine, many female physicians made  
8 adjustments in their professional roles, including “part-time status, despite the known limitations  
9 on professional progression, career advancement, and economic potential. These adjustments  
10 further propagate gender inequities and the persistent compensation gap female physicians  
11 experience;”<sup>3</sup> and  
12

13 Whereas, The COVID-19 pandemic is requiring additional adjustments to the professional lives  
14 of physicians and many of these adjustments will be made disproportionately by female  
15 physicians due to childcare and pregnancy;<sup>4</sup> and  
16

17 Whereas, Since the pandemic, there has been a decrease in the percentage of physicians  
18 working full-time, a rise in the percentage who were laid off, and an increase in changes in  
19 physicians’ usual activities. The decline in the percentage of parents with preschool-aged  
20 children among only female physicians may suggest a disproportionate uptake of childcare  
21 responsibilities among female physicians;<sup>5</sup> and  
22

23 Whereas, In a recent survey, female scientists reported a decline in research time relative to  
24 male colleagues during the COVID-19 pandemic, but the most significant factor was having a  
25 young dependent less than 6 years of age;<sup>6</sup> and  
26

27 Whereas, One in five physicians experienced a financial cut or furlough because of the  
28 pandemic, but there is limited data on how these cuts and furloughs have impacted female  
29 physicians specifically<sup>7</sup>; therefore be it  
30

31 RESOLVED, That our American Medical Association advocate for research on physician-  
32 specific data analyzing changes in work patterns and employment outcomes among female  
33 physicians during the pandemic including, but not limited to, understanding potential gaps in  
34 equity, indications for terminations and/or furloughs, gender differences in those who had  
35 unpaid additional work hours, and issues related to intersectionality (Directive to Take Action);  
36 and be it further  
37

38 RESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles  
39 affecting female physicians and medical students during the pandemic. (Directive to Take  
40 Action)

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

Received: 03/31/22

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4. Brubaker L. Women Physicians and the COVID-19 Pandemic. *JAMA.* 2020;324(9):835–836. doi:10.1001/jama.2020.14797
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6. Myers K.R., Tham W.Y., Yin Y. Unequal effects of the COVID-19 pandemic on scientists. *Nat Human Behav.* 2020;4:880–883.
7. Paavola, A., 1 in 5 physicians hit with high pay cuts or furlough due to COVID-19, survey says. Beck Hospital review. April 22, 2020. [www.beckerhospitalreview.com](http://www.beckerhospitalreview.com)

### RELEVANT AMA POLICY

#### Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

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

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

Citation: BOT Rep. 27, A-19

**AMA Principles for Physician Employment H-225.950****1. Addressing Conflicts of Interest**

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

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

**2. Advocacy for Patients and the Profession**

- a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
- b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

**3. Contracting**

- a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

- c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
- (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
- (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
- (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
- (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

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

#### **4. Hospital Medical Staff Relations**

- a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any



matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

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

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

## **5. Peer Review and Performance Evaluations**

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

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

## **6. Payment Agreements**

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

*Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.*

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(A-22)

Introduced by: Medical Student Section

Subject: Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, The Association of American Medical Colleges (AAMC) has defined  
2 underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are  
3 underrepresented in the medical profession relative to their numbers in the general population"  
4 since 2003, with an overarching goal to advocate for population parity<sup>1</sup>; and  
5

6 Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering  
7 diversity as referring solely to race and ethnicity is too narrow and that broadening the definition  
8 of diversity would help to encompass sexual orientation, religion, geography, disability, age,  
9 language, and gender identity<sup>2</sup>; and  
10

11 Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their  
12 sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as  
13 transgender; the last two components of the acronym can stand for queer or questioning and  
14 are meant to encompass all identities that are not heterosexual or cisgender<sup>3</sup>; and  
15

16 Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation,  
17 gender identity, or both of these identity aspects<sup>3-5</sup>; and  
18

19 Whereas, The National Institutes of Health (NIH) formally designated sexual and gender  
20 minorities (SGMs) as a health disparity population for NIH research due to mounting evidence  
21 that SGM populations have less access to healthcare and higher burdens of diseases such as  
22 depression, cancer, and HIV/AIDS<sup>6</sup>; and  
23

24 Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of  
25 heterosexual healthcare providers reported moderate to strong implicit preference for  
26 heterosexual patients over homosexual patients, while gay and lesbian providers showed more  
27 implicit preference in favor of homosexual patients<sup>7</sup>; and  
28

29 Whereas, In 2015, the American College of Physicians emphasized the need for "programs that  
30 would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer  
31 support to LGBT medical students, residents, and practicing physicians"<sup>8</sup>; and  
32

33 Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+  
34 people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth  
35 have experienced social ostracism because of their LGBTQ+ identity<sup>9</sup>; and

Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable<sup>10-12</sup>; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"<sup>13</sup>; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity(Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

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

Date received: 04/08/22

#### References:

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**RELEVANT AMA POLICY:****Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322**

Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.

Citation: Res. 313, A-09; Modified: CME Rep. 6, A-11; Reaffirmed: CME Rep. 1, A-21

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

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

**Medical Staff Development Plans H-225.961**

All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment

to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.  
Citation: BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation A-10; Modified: CMS Rep. 01, A-20

**Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878**

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005  
(A-22)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural  
2 policies targeting minorities, especially the Black community, including disproportionate rates of  
3 incarceration,<sup>5-7</sup> residential segregation,<sup>8</sup> and unfair labor and employment policies;<sup>1-4</sup> and  
4

5 Whereas, Toxic stresses of racism, incarceration, community violence, and low socioeconomic  
6 status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk  
7 behavior<sup>10</sup>, disease, and early death in minority children<sup>9, 11,12</sup>; and  
8

9 Whereas, The racial wealth gap in the United States has increased dramatically, as households  
10 with Black children hold just one cent for every dollar held by households with non-Hispanic  
11 White children as of 2016<sup>13,14</sup>; and  
12

13 Whereas, Income has been shown to be positively correlated with life expectancy, increased  
14 access to care, and improved health outcomes<sup>15,16</sup>; and  
15

16 Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to  
17 education and job opportunities, which are correlated with positive health outcomes, for the  
18 African American community<sup>17,18,19,20</sup>; and  
19

20 Whereas, The United States has never created a commission to formally study the health,  
21 economic or social impacts of slavery and the Jim Crow era on African Americans and the  
22 resolution of those injustices through the context of reparations<sup>14,21</sup>; and  
23

24 Whereas, Reparations, encompassing a broad variety of public aid including but not limited to  
25 direct compensation, special education and job training, and community support for  
26 descendants of slaves, have been discussed as a means to support the marginalized Black  
27 community and end multi-generational poverty and its associated racial inequities<sup>21</sup>; and  
28

29 Whereas, In 2015, Chicago became the first city in the United States to propose reparations for  
30 victims of police torture and brutality, in a measure including \$5.5 million in direct compensation,  
31 free college education to survivors, a formal apology from the city, and education on police  
32 torture in public schools<sup>22</sup>; and  
33

34 Whereas, Reparations are designed to promote intergenerational wealth amongst affected  
35 communities, which in turn will increase the health outcomes of these communities; and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: "Commission to Study Reparation Proposals for African Americans Act," which asked for a study of reparations, into Congress every year since 1989<sup>14,21,23</sup>; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes<sup>23-25</sup>; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over \$60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past<sup>26,27</sup>; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation<sup>28-30</sup>; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population<sup>14,30,31</sup>; and

Whereas, The Black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly Black medical schools after the 1910 publication of the Flexner Report<sup>31</sup>; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships<sup>32,33</sup>; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders<sup>33</sup>; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (New HOD Policy)

Fiscal Note: Estimated cost to implement resolution is \$110,000.

Date Received: 04/08/22



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## RELEVANT AMA POLICY

### Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

### AMA Initiatives Regarding Minorities H-350.971

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

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

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

Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

### Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

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

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

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

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

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

### **Reducing Racial and Ethnic Disparities in Health Care D-350.995**

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

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006  
(A-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

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

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

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

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

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

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

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

35 Whereas, Studies show "a positive association between physician-patient racial/ethnic  
36 concordance and patients' receiving preventive care, being satisfied with their care overall..." <sup>12</sup>;  
37 and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy)

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

Date Received: 04/08/22

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## RELEVANT AMA POLICY

### Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;

6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

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

BOT Rep. 27, A-19

#### **Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14, Reaffirmed in lieu of: Res. 001, I-16, Reaffirmation: A-17

#### **Teacher-Learner Relationship In Medical Education H-295.955**

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

#### **CODE OF BEHAVIOR**

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98, Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07, Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

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

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
  3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
  4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
  5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
- Res. 307, A-09, Appended: Res. 955, I-17

### **Eliminating Religious Discrimination from Residency Programs H-310.923**

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances.

CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16

### **Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984**

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

BOT Action in response to referred for decision: Res. 602, I-15



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007  
(A-22)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and  
2 Immigration Services (USCIS) are as follows:

- 3
- 4 1. You must be a U.S. Citizen.
- 5 2. If you are unmarried, you must be at least 25 years old.
- 6 3. If you are married, you must jointly adopt the child (even if you are separated but  
7 not divorced), and your spouse must also be either a U.S. citizen or in legal  
8 status in the United States.
- 9 4. You must meet certain requirements that will determine your suitability as a  
10 prospective adoptive parent, including criminal background checks,  
11 fingerprinting, and a home study<sup>1</sup>; and  
12

13 Whereas, The federal government currently allocates funding for adoption and foster care to  
14 states, which independently manage federal funds and have differing statutes concerning  
15 eligibility to adopt or place a child up for adoption<sup>2-4</sup>; and  
16

17 Whereas, Independent state-licensed child welfare agencies are contracted by each state to  
18 provide foster care or adoption services<sup>5</sup>; and  
19

20 Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how  
21 “state-sanctioned discrimination against LGBT individuals who wish to raise children has  
22 dramatically increased in recent years”<sup>6-7</sup>; and  
23

24 Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of  
25 children with LGBTQ individuals and same-sex couples and fourteen additional states lack  
26 explicit protection for LGBTQ individuals concerning adoption rights<sup>5</sup>; and  
27

28 Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283  
29 total children in the U.S. foster care system with 125,422 children waiting to be adopted<sup>8</sup>; and  
30

31 Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System  
32 (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the  
33 system<sup>8</sup>; and  
34

35 Whereas, The longer a child is in foster care, the more likely that child is to move from one  
36 foster placement to another, and the greater the risk that child experiences adverse childhood  
37 events (ACEs), which may result in lasting negative social and emotional consequences<sup>9</sup>; and

Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster care with no known internal or external problems show an increase in “total problem behavior” in direct correlation with their number of placements<sup>10-12</sup>; and

Whereas, Frequent placement changes result in difficulty forming secure attachments with foster parents, low self-esteem, and a negative relationship with academic growth<sup>10-12</sup>; and

Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential”<sup>13</sup>; and

Whereas, Recent social science literature supports that children living with same-sex parents have equivalent outcomes compared to children with different-sex parents<sup>14</sup>; and

Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to adopt children under age 18 compared to different sex couples<sup>15-16</sup>; and

Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care that addresses the specific health care needs of children in foster care” and supports the “best interest of the child” as the most important criterion determining custody, placement, and adoption of children;” and

Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of their co-parenting partner but does not adequately address adoption rights of LGBTQ individuals nor their limited eligibility or access to adoption, allowing for potential harm towards children by narrowing the pool of qualified foster and adoptive homes; therefore be it

RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (New HOD Policy)

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

Date Received: 04/08/22

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## RELEVANT AMA POLICY

### Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children.

Sub. Res. 219, I-93Reaffirmed: BOT Rep. 28, A-03Reaffirmed: BOT Rep. 28, A-13

### Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17

### Partner Co-Adoption H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child.

Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

### Health Care disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

CSAPH Rep. 1, I-09; BOT Action in response to referred for decision; Res. 918, I-09;

Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

**Adoption H-420.973**

It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.

Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

**Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008  
(A-22)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, School-related arrests and juvenile justice referrals have been associated with school  
2 disengagements, lower graduation rates, increased dropout rates, and increased involvement in  
3 the school-to-prison pipeline<sup>1, 2</sup>; and  
4

5 Whereas, School-related arrests and juvenile justice referrals disproportionately target Black  
6 students, Latinx students, male students, and students with physical or mental disabilities<sup>3, 4, 5</sup>;  
7 and  
8

9 Whereas, Research on the effectiveness of school resource officer programs is limited, and fails  
10 to make a strong case for harsh discipline programs that include referral to law enforcement<sup>6</sup>;  
11 and  
12

13 Whereas, School-based mental health efforts have been successful in identifying those in need  
14 of mental health services, bolstering academic functioning, and improving patterns of behavior<sup>7</sup>;  
15 and  
16

17 Whereas, Educators, nurses, and counselors can play a key role in fostering protective  
18 environments for children and identifying students who may need additional support, in contrast  
19 to school resource officers<sup>8, 9</sup>; and  
20

21 Whereas, School-based mental health professionals report ever-increasing workloads and  
22 responsibilities that include disciplinary roles<sup>10, 11</sup>; and  
23

24 Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental  
25 health, or social issues because they do not feel that their disclosure will be kept private,  
26 possibly affecting their academic or conduct standing<sup>12</sup>; and  
27

28 Whereas, The American School Counselor Association urges that “school counselors maintain  
29 non-threatening relationships with students to best promote student achievement and  
30 development” and states that school counselors are neither “disciplinarians” or “enforcement  
31 agent[s] for the school”<sup>13</sup>; and  
32

33 Whereas, The National Association of School Nurses states that school nurses should facilitate  
34 an “environment that values connecting students, families, and the community in positive  
35 engagement” characterized by “safety and trust where students are aware that caring, trained  
36 adults are present and equipped to take action on their behalf”<sup>14</sup>; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the academic, social, emotional, and behavioral competence of students at all levels of education<sup>15</sup>; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"<sup>15</sup>; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior<sup>16</sup>; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions<sup>17, 18</sup>; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of "zero tolerance" policies and have advocated for school wide PBIS as an alternative<sup>19, 20</sup>; and

Whereas, AMA policy H-60.919 includes support for "school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments," but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA policy H-60.902 addresses the need for policy ensuring proper qualification and training for school resource officers, but do not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

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

Date Received: 04/08/22

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## RELEVANT AMA POLICY

### Juvenile Justice System Reform, H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

### **School-Based and School-Linked Health Centers, H-60.921**

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

CSAPH Rep. 1, A-15

### **Adolescent Health, H-60.981**

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.

Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07;

Reaffirmed CSAPH Rep. 01, A-17

### **Providing Medical Services Through School-Based Health Programs, H-60.991**

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should



be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

### **Improving Pediatric Mental Health Screening, H-345.977**

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

### **Access to Mental Health Services, H-345.981**

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

- (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
- (2) improving public awareness of effective treatment for mental illness;
- (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
- (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
- (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
- (6) reducing financial barriers to treatment.

CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

### **School Resource Officer Qualifications and Training, H-60.902**

Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Res. 926, I-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009  
(A-22)

Introduced by: Illinois

Subject: Privacy Protection and Prevention of Further Trauma for Victims of  
Distribution of Intimate Videos and Images Without Consent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Nonconsensual pornography is a relatively new phenomenon that has grown  
2 substantially in the past few years, and involves uploading nude or semi-nude images/videos of  
3 a person online without their consent; and  
4

5 Whereas, 80 to 93 percent of victims suffer significant emotional distress after the release of  
6 their explicit photographs; and  
7

8 Whereas, Victims are not only cyber harassed by their abuser, but also by online users who  
9 have viewed their posted photographs; and  
10

11 Whereas, The impact of nonconsensual pornography includes public shame and humiliation, an  
12 inability to find new romantic partners, mental health effects such as depression and anxiety, job  
13 loss or problems securing new employment, and offline harassment and stalking; and  
14

15 Whereas, Cyberbullying violence is associated with a range of mental health issues, including  
16 behavioral and emotional problems, reduced self-esteem and substance use; and  
17

18 Whereas, Victims may suffer termination of employment or may have difficulty gaining future  
19 employment and some victims resort to changing their names in an attempt to escape their  
20 past; and  
21

22 Whereas, Once a photo is posted online, it is challenging to completely remove from the  
23 Internet, which means the harm is continuous and long lasting; and  
24

25 Whereas, Many victims experience severe mental health effects and are diagnosed with post-  
26 traumatic stress disorder, anxiety, and depression; and  
27

28 Whereas, Post-traumatic stress disorder is associated with an increased risk of disease,  
29 including chronic musculoskeletal pain, hypertension, and cardiovascular disease; and  
30

31 Whereas, Exposure to stimuli that is triggering to the traumatic memory in post-traumatic stress  
32 disorder leads to increased sensitization, and increases the severity of individual psychosomatic  
33 sequelae over time; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-515.967, "Protection of  
2 the Privacy of Sexual Assault Victims," by addition to read as follows:

3  
4 Protection of the Privacy of Sexual Assault Victims H-515.967

5 The AMA opposes the publication or broadcast of sexual assault victims' names,  
6 addresses, images or likenesses without the explicit permission of the victim. The  
7 AMA additionally opposes the publication (including posting) or broadcast of videos,  
8 images, or recordings of any illicit activity of the assault. The AMA opposes the use  
9 of such video, images, or recordings for financial gain and/or any form of benefit by  
10 any entity. (Modify Current HOD Policy)

11  
12 RESOLVED, That our AMA research issues related to the distribution of intimate videos and  
13 images without consent to find ways to protect these victims to prevent further harm to their  
14 mental health and overall well-being. (Directive to Take Action)

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

Received: 04/08/22

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**RELEVANT AMA POLICY:**

**Protection of the Privacy of Sexual Assault Victims H-515.967**

The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim.

Citation: Res. 406, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CEJA Rep. 03, A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010  
(A-22)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Sex work entails the provision of sexual services for money or goods, while sex  
2 trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a  
3 person for the purpose of a commercial sex act<sup>1-3</sup>; and  
4

5 Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter,  
6 food, or money; survival sex is considered a subset of “sex work” since it does not involve the  
7 force, fraud, or explicit coercion defined in sex trafficking<sup>4</sup>; and  
8

9 Whereas, Consent is defined by the federal government as a freely given agreement to the  
10 conduct at issue by a competent person, and consent is not constituted by lack of verbal or  
11 physical resistance<sup>5-7</sup>; and  
12

13 Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—  
14 often problematically falls under the term “consensual” sex work; thus, consent in the realm of  
15 sex work falls on a spectrum, rather than a binary definition<sup>5-7</sup>; and  
16

17 Whereas, Globally, the three major policy approaches to sex trade regulation are (1)  
18 criminalization, (2) full and partial decriminalization, and (3) legalization, and the US primarily  
19 uses criminalization; and  
20

21 Whereas, Criminalization of the selling of sex is associated with higher prevalence of unsafe  
22 practices such as not using condoms, higher rates of sexually transmitted infections (STIs),  
23 lower likelihood of seeking healthcare for illness or injury related to sex work, and greater  
24 likelihood of violence and rape of the individuals selling sex<sup>8-17</sup>; and  
25

26 Whereas, Criminalization of the selling of sex is associated with higher rates of sexual  
27 harassment, rape, and violence perpetrated by police against people selling sex<sup>17-20</sup>; and  
28

29 Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers  
30 were four times more likely to report mental health issues, possibly due to increased risks that  
31 come with illegal sex work such as assault and arrest<sup>21</sup>; and  
32

33 Whereas, Because sex work is criminalized in the United States, many sex workers struggle to  
34 obtain health insurance, leading to the majority being uninsured and paying out of pocket for  
35 healthcare<sup>22</sup>; and  
36

37 Whereas, In 2019, nearly 27,000 people, many of whom were parents, were arrested for  
38 prostitution and commercial vices in the United States, putting their children at an increased risk  
39 for depression, anxiety, antisocial behavior, drug use, and cognitive delays<sup>23,24</sup>; and

1 Whereas, Many sex workers have criminal records from the criminalization of selling sex, which,  
2 in conjunction with a high rate of mental health problems including increased rates of  
3 depression, PTSD, suicidality, dissociation, and substance use disorders, poses a significant  
4 barrier in attaining the economic stability needed to successfully exit the sex industry and attain  
5 and maintain other employment<sup>25-31</sup>; and  
6

7 Whereas, A study of 854 sex workers' experiences found 89% of them reported wanting to  
8 leave sex work, but named lack of safety, job training, and financial and psychological support  
9 and other barriers as preventing their leaving, and other smaller studies have had similar  
10 findings and shown that leaving the sex industry usually takes multiple attempts of exit-reentry-  
11 exit cycles<sup>25,32-34</sup>; and  
12

13 Whereas, A systematic review of the literature estimates that 15-20% of men in the United  
14 States have paid for sex at least once; and surveys show up to 37% of buyers believe that if  
15 they pay for sex, the sex worker is obligated to do anything they ask, and 19% admit to having  
16 committed rape<sup>35-39</sup>; and  
17

18 Whereas, Individuals who sell sex for survival are often those from among the most vulnerable  
19 communities, such as undocumented immigrants, minoritized racial and ethnic populations, the  
20 economically marginalized, homeless or runaway youth, homeless populations in general and  
21 especially homeless LGBTQ+ populations, and transgender people<sup>20,40-49</sup>; and  
22

23 Whereas, In a nationwide study, 12% of trans women reported earning income through sex  
24 work, with higher rates among trans women of color, with 77% of these women reported  
25 intimate partner violence, 72% reported sexual assault, and 86% reported police harassment<sup>20</sup>;  
26 and  
27

28 Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work  
29 Projects, Amnesty International, and Human Rights Watch all recommend decriminalizing  
30 consensual sex work to improve access to health care for high-risk populations, with the WHO  
31 specifying that decriminalization would help reduce HIV incidence<sup>17,50,51</sup>; and  
32

33 Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex,  
34 acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely followed  
35 system of partial decriminalization and is employed in Sweden, Norway, Iceland, France,  
36 Ireland, Northern Ireland, Canada, and Israel<sup>52</sup>; and  
37

38 Whereas, In the Equality Model, people currently selling sex are offered voluntary participation  
39 in social services, and people found to be buying sex are offered voluntary participation  
40 programs to help them stop buying sex<sup>52</sup>; and  
41

42 Whereas, Partial decriminalization strategies such as the Equality Model are associated with a  
43 markedly lower rate of human trafficking, while full decriminalization and legalization are  
44 associated with (1) increases in human trafficking to meet the increased demand for commercial  
45 sex, as well as (2) increases in organized crime<sup>52-54</sup>; and  
46

47 Whereas, Transition from criminalization to the decriminalization of the sale of sex in the  
48 Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a  
49 comparatively lower number of persons trafficked compared to surrounding nations using other  
50 policy systems<sup>45,55,56</sup>; and

Whereas, An article in the *AMA Journal of Ethics* suggested the Equality Model, to be the most effective and ethical approach to addressing the issue of sex work and human rights violations<sup>57</sup>; and

Whereas, Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population<sup>45,50-57</sup>; and

Whereas, Although research has documented the effects of current involvement in the sex industry, research on long-term impacts remains scarce<sup>32,58</sup>; therefore be it

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy)

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

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## RELEVANT AMA POLICY

### Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Citation: Res. 009, A-17

### Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958

Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and best practices. Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.

Citation: Res. 14, A-15; Modified: Res. 003, I-17

### HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;



- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

### **Global HIV/AIDS Prevention H-20.898**

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.

Citation: Res. 439; A-08; Modified: Res. 003, I-17

### **Physicians Response to Victims of Human Trafficking H-65.966**

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  - a. An assessment tool for health care professionals
  - b. Online training in recognizing and responding to human trafficking in a health care context
  - c. Speakers and materials for in-person training
  - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

Citation: (BOT Rep. 20, A-13; Appended: Res. 313, A-15)

### **Human Trafficking / Slavery Awareness D-170.992**

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Citation: Res. 015, A-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011  
(A-22)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Race is a self-identified social construct that results in differential treatment of groups  
2 that leads to social inequity on people's health<sup>1,2</sup>; and  
3

4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-  
5 identification of their origin or descent, "roots," heritage, or place where the individual or their  
6 parents or ancestors were born<sup>3</sup>; and  
7

8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);  
9 and  
10

11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as  
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and  
13 Chicano/a/x" have been used interchangeably with race in case report<sup>4-7</sup>; and  
14

15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of  
16 origin and cultural heritage, constructs which can change over time<sup>8,9</sup>; and  
17

18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based  
19 consensus is necessary for optimal use of self-identified race as well as geographical  
20 ancestry<sup>10</sup>; and  
21

22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can  
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine<sup>11</sup>;  
24 and  
25

26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated  
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast  
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency  
29 department<sup>12</sup>; and  
30

31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in  
32 2015, there was substantial variation between states in administrative data misclassification of  
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native  
34 beneficiaries<sup>13</sup>; and  
35

36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the  
37 62 studies provided complete descriptions of their study populations<sup>14</sup>; and  
38

39 Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to  
40 be inconsistent with current understanding of race and ethnicity<sup>15</sup>; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results<sup>16</sup>; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in Black patients<sup>16</sup>; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology<sup>16-18</sup>; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and White women<sup>4</sup>; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in Black women<sup>19</sup>; and

Whereas, The rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women is less than that of U.S.-born Black women and approximates those of U.S.-born White women, suggesting no significant genetic basis to race differences<sup>4</sup>; and

Whereas, Our AMA Board of Trustees on June 7<sup>th</sup>, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care, and our House of Delegates has adopted multiple policies recognizing racism as a public health threat (H-65.952) and the harm of racial essentialism in medicine and of using race as biology (D-350.981, H-65.953)<sup>20</sup>; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” and “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias<sup>21</sup>; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

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

Received: 04/08/22

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## RELEVANT AMA POLICY

### Code of Medical Ethics 7.1.5

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
- (b) Resolve charges expeditiously.
- (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
- (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
- (e) Maintain accurate and thorough documentation throughout the process.
- (f) Maintain the highest degree of confidentiality.
- (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.

Issued: 2016

### Code of Medical Ethics Opinion 8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate

variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

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

Issued: 2016

### **Racial and Ethnic Disparities in Health Care H-350.974**

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

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

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

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

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

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

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields

related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

#### **Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984**

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Citation: BOT Action in response to referred for decision Res. 602, I-15

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

Our AMA supports:

- (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
- (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
- (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
- (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Citation: CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

#### **Reducing Racial and Ethnic Disparities in Health Care D-350.995**

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

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

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

#### **Strategies for Eliminating Minority Health Care Disparities D-350.996**

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Citation: (Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

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

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

#### **Racial Essentialism in Medicine D-350.981**

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20

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

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012  
(A-22)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The World Health Organization has unequivocally defined infertility as a disease state  
2 and a cause of disability<sup>1</sup>; and  
3

4 Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for  
5 transgender men, which can suppress ovulation, and estrogen therapy for transgender women,  
6 which can lead to impaired spermatogenesis and testicular atrophy<sup>2,3</sup>; and  
7

8 Whereas, Gender-affirming surgery (GAS) can include hysterectomy and oophorectomy, which  
9 results in permanent sterility<sup>2,3</sup>; and  
10

11 Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of  
12 respondents had received GAHT and 25% had undergone some form of GAS<sup>4</sup>; and  
13

14 Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine  
15 Society, and the American Society for Reproductive Medicine (ASRM) all recommend that  
16 transgender individuals receive counseling regarding potential loss of fertility and future  
17 reproductive options before initiating GAHT or undergoing GAS<sup>5-7</sup>; and  
18

19 Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care  
20 Act created protections barring insurance discrimination based on sexual orientation and gender  
21 identity, although the current Administration has declined to defend this regulation and has been  
22 deferential to states<sup>8-10</sup>; and  
23

24 Whereas, Employers and states that have implemented coverage of transition-related services  
25 have demonstrated minimal or no costs with vast immaterial/societal benefits<sup>10,11</sup>; and  
26

27 Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of  
28 economic benefit, it is still difficult for transgender patients to obtain insurance coverage for  
29 gender-affirming care, fertility counseling, and gamete preservation<sup>3,4,12</sup>; and  
30

31 Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with  
32 specific requirements determined on a state-by-state basis<sup>12,13</sup>; and  
33

34 Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New  
35 York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around  
36 qualifying diagnoses is variable between states<sup>12,13</sup>; and



Whereas, “Iatrogenic infertility” has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes<sup>12</sup>; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient’s physician (H-185.950)<sup>7,14</sup>; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is “caused directly or indirectly by necessary medical treatments as determined by a licensed physician” (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage.” by addition to read as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

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

Received: 04/08/22

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**RELEVANT AMA POLICY****Right for Gamete Preservation Therapies H-65.956**

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

**Infertility and Fertility Preservation Insurance Coverage H-185.990**

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

**Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Citation: Res. 122; A-08; Modified: Res. 05, A-16

**Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980**

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Citation: Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07;

Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

#### **Infertility Benefits for Veterans H-510.984**

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19;

#### **Storage & Use of Human Embryos- Ethics 4.2.5**

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:

- (a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
- (b) Made available to other patients for purposes of reproduction.
- (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
- (d) Allowed to thaw and deteriorate.
- (e) Otherwise disposed of.

Under no circumstances should physicians participate in the sale of stored embryos

Issued: 2016

**Assisted Reproductive Technology- Ethics 4.2.1**

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. "Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Issued: 2016

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013  
(A-22)

Introduced by: Resident and Fellow Section

Subject: Recognition of National Anti-Lynching Legislation as Public Health Initiative

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Lynching is defined “as to put to death by mob action without legal approval or  
2 permission”<sup>1,2</sup>; and  
3

4 Whereas, In the 20th century lynching occurred mostly in southern states by White southerners  
5 against Black southerners, however, it was not limited to this region alone nor to Black  
6 Americans. Other minority populations were vulnerable to experiencing lynching such as  
7 Latinos, Native Americans and Asian Americans<sup>3,4</sup>; and  
8

9 Whereas, Historical trauma is defined by the U.S. Department of Health and Human Services as  
10 “multigenerational trauma experienced by a specific cultural, racial or ethnic group”<sup>3,4</sup>; and  
11

12 Whereas, Health outcomes and impact related to historical trauma can be defined by the U.S.  
13 Department of Health and Human Services as depression, fixation on trauma, low self-esteem,  
14 anger and self-destructive behavior and can be experienced by descendants who have not  
15 directly experienced a traumatic event<sup>4-7</sup>; and  
16

17 Whereas, Today’s vulnerable populations experience historical trauma that can be contributed  
18 to lynching practices under the Jim Crow period (1870-1965)<sup>7</sup>; and  
19

20 Whereas, In 1947, the journal of the National Medical Association called for lynching to be  
21 named a federal offense as “...there is only one remedy and that is for Congress to enact a law  
22 making lynching a federal crime to be tried not by a local jury but in a United States court...”<sup>8</sup>;  
23 and  
24

25 Whereas, Current bill H.R.55 introduced in the 117th Congress known as the “Emmett Till  
26 Antilynching Act” has been introduced into Congress for more than 120 years and has not  
27 passed due to Congressional mishandlings<sup>9,10</sup>; and  
28

29 Whereas, H.R. 55 and previous iterations of this Act are focused on amending section 249 of  
30 Title 18, United States Code, to specify lynching as a hate crime act<sup>9,10</sup>; and  
31

32 Whereas, Current AMA policy H-65.965, “Support of Human Rights and Freedom” states, “Our  
33 AMA recognizes that hate crimes pose a significant threat to the public health and social welfare  
34 of the citizens of the United States, urges expedient passage of appropriate hate crimes  
35 prevention legislation in accordance with our AMA’s policy through letters to members of  
36 Congress; and registers support for hate crimes prevention legislation, via letter, to the  
37 President of the United States”; therefore be it

1 RESOLVED, That our American Medical Association support national legislation that recognizes  
 2 lynching and mob violence towards an individual or group of individuals as a hate crimes (New  
 3 HOD Policy); and be it further  
 4

5 RESOLVED, That our AMA work with relevant stakeholders to support medical students,  
 6 trainees and physicians receiving education on the inter-generational health outcomes related to  
 7 lynching and its impact on the health of vulnerable populations (Directive to Take Action); and  
 8 be it further  
 9

10 RESOLVED, That AMA policy H-65.965, Support of Human Rights and Freedom, be amended  
 11 by addition to read as follows:  
 12

13 Our AMA: (1) continues to support the dignity of the individual, human rights and the  
 14 sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the  
 15 denial to any human being of equal rights, privileges and responsibilities commensurate  
 16 with his or her individual capabilities and ethical character because of an individual's  
 17 sex, sexual orientation, gender, gender identity or transgender status, race, religion,  
 18 disability, ethnic origin, national origin or age; (3) opposes any discrimination based on  
 19 an individual's sex, sexual orientation, gender identity, race, phenotypic appearance,  
 20 religion, disability, ethnic origin, national origin or age and any other such reprehensible  
 21 policies; (4) recognizes that hate crimes pose a significant threat to the public health  
 22 and social welfare of the citizens of the United States, urges expedient passage for  
 23 appropriate hate crimes prevention legislation in accordance with our AMA's policy  
 24 through letters to members of Congress; and registers support for hate crimes  
 25 prevention legislation, via letter, to the President of the United States (Modify Current  
 26 HOD Policy); and be it further  
 27

28 RESOLVED, That our AMA reaffirm policy H-65.952 "Racism as a Public Health Threat".  
 29 (Reaffirm HOD Policy)

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

Received: 04/08/22

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## RELEVANT AMA POLICY

### **Adverse Childhood Experiences and Trauma-Informed Care H-515.952**

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
  - a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
  - b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
  - c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
  - d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
  - e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
  - f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Citation: Res. 504, A-19; Appended: CSAPH Rep. 3, A-21;

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

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20;

### **Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation,

gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17