OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinions were presented by Peter A. Schwartz, MD, Chair:

1. AMENDMENT TO OPINION 4.2.7, "ABORTION"

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-22, "Amendment to Opinion 4.2.7, 'Abortion.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-4.2.7 – Abortion

Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment.

The *Principles of Medical Ethics* of the AMA permit physicians to perform abortions in keeping with good medical practice. (III, IV)

2. AMENDMENT TO OPINION 10.8, "COLLABORATIVE CARE"

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-22, "Amendment to Opinion 10.8, 'Collaborative Care.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-10.8 – Collaborative Care

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 the integrity of the patient-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 healing relationships between patients and physicians or nonphysician practitioners, 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, respecting the unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

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

(g) 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.

(h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(i) 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.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel. (II, V, VIII)

3. PANDEMIC ETHICS AND THE DUTY OF CARE

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-I-22, "Pandemic Ethics and the Duty of Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

RECOMMENDATION

E-8.3 – Physician Responsibility in Disaster Response and Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured,

individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.

Many physicians owe competing duties of care as medical professionals and as individuals outside their professional roles. In a public health crisis, institutions should provide support to enable physicians to meet compelling personal obligations without undermining the fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to allow the physician to honor both obligations are not feasible, it may be ethically acceptable for a physician to limit participating in care, provided that the institution has made available another mechanism for meeting patients' needs. Institutions should strive to be flexible in supporting physicians in efforts to address such conflicts. The more immediately relevant a physician's clinical expertise is to the urgent needs of the moment and the less that alternative care mechanisms are available, the stronger the professional obligation to provide care despite competing obligations.

With respect to disaster, whether natural or manmade, individual physicians should:

(a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

(b) Provide medical expertise and work with others to develop public health policies that:

    (i)   Are designed to improve the effectiveness and availability of medical services during a disaster
    (ii)   Are based on sound science

    (iii) Are based on respect for patients

(c) Advocate for and participate in ethically sound research to inform policy decisions.
    (V, VI, VII, VIII)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Peter A. Schwartz, MD, Chair:

1. UTILIZATION REVIEW, MEDICAL NECESSITY DETERMINATION, PRIOR AUTHORIZATION DECISIONS

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

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                      REMAINDER OF REPORT FILED
                      See Policy D-320.977

Policy D-320.977, "Utilization Review, Medical Necessity Determination, Prior Authorization Decisions," as adopted in June 2022, requests that the Council on Ethical and Judicial Affairs "review current ethical opinions similar to the Texas Medical Association (TMA) Board of Councilors' opinions regarding medical necessity determination and utilization review."

The relevant TMA Board of Councilors opinions read as follows:

> MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine; it is not a benefit determination. Whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization. That physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary. Although the physician may take cost considerations into account, the physician may not refuse to approve the medical necessity of a treatment simply based on cost, and must approve the treatment if it is clearly more therapeutically effective than other treatment options that may be covered under the plan, even if those treatment options are less expensive than their more costly counterpart.

> UTILIZATION REVIEW. The physician who performs prospective and/or concurrent utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated.

As originally presented to the American Medical Association (AMA) House of Delegates, the background resolution asked that Council on Ethical and Judicial Affairs (CEJA) "devise ethical opinions similar to" those issued by the TMA Board of Councilors (Resolution 727 A-22).

The opinions of the TMA maintain that decisions about the appropriateness of recommended interventions are matters of professional medical judgment, not administrative determinations. Thus, physicians charged to determine whether an intervention is medically necessary on behalf of health care organizations or third-party payers

- may not refuse to approve treatment based solely on cost considerations; and
- must approve treatment that is "clearly more therapeutically effective" even if it is costlier than other covered options.

Physicians who perform utilization review likewise should base determinations on the standard of care prevailing in the professional community.

The council reviewed existing guidance in the AMA *Code of Medical Ethics* and concluded that issues raised by the opinions of the TMA are appropriately addressed in several opinions:

- 10.1 "Ethics Guidance for Physicians in Nonclinical Roles"
- 10.1.1 "Ethical Obligations of Medical Directors"
- 11.2.1 "Professionalism in Health Care Systems"

- 11.2.2 "Conflicts of Interest in Patient Care"
- 11.2.3 "Contracts to Deliver Health Care Services"
- 11.2.6 "Mergers of Secular and Religiously Affiliated Health Care Institutions"
- 11.1.2 "Physician Stewardship of Health Care Resources"

Opinions 10.1 and 10.1.1 maintain that whenever physicians "use the knowledge and values they gained through medical training . . . in roles that affect the care and well-being" of patients, physicians are "functioning within the sphere of their profession" and must uphold their fiduciary obligations to patients. Opinion 11.2.2 holds patient welfare takes priority over the economic interests of hospitals, health care organizations, and other entities.

Opinion 11.2.1 sets out essential conditions for the ethically appropriate design and use of incentives to address health care costs. Rather than address specific mechanisms or strategies, guidance identifies key ethics concerns, particularly conflict of interest and implications for physicians' exercise of professional judgment and professionalism. Thus 11.2.1 defines essential conditions for the ethical use of incentives, irrespective of the form such incentives may take:

- ensuring that health care disparities are not exacerbated
- ensuring that supporting infrastructure and resources are in place to support high quality care and physician professionalism
- recognizing and respecting physicians' duty to advocate on behalf of patients by providing meaningful pathways for appealing denials of care
- accepting an institutional obligation to monitor the impact of incentives

Although it speaks less directly to matters of determining medical necessity or utilization review, Opinion 11.2.6 similarly underscores the importance of ensuring that health care institutions adopt mechanisms to enable physicians to appeal constraints in order to meet the unique needs of individual patients and to monitor the impact of policies that constrain resource use or the availability of clinical services.

Finally, Opinion 11.1.2 addresses the position expressed by the TMA that physicians should approve "clearly more therapeutically effective" among available options, irrespective of cost. 11.1.2 provides that physicians should recommend interventions "demonstrated to meaningfully improve clinical outcomes," although when different interventions offer comparable benefits and risks for an individual patient, they should generally prefer those that require fewer resources.

The council further noted that amending guidance specifically to address determinations of medical necessity and utilization review as such would not be consistent with the approach taken in modernizing the *Code of Medical Ethics*. In updating the *Code* CEJA intentionally reframed guidance to ensure that it remained "evergreen" and not tied to specific technologies or practices. The council focused on clarifying the ethical values underlying guidance and for the most part eliminated specific examples and content that read as instruction on how to implement guidance.

Multiple opinions in earlier editions of the *Code* spoke to particulars of, e.g., capitation, use of restricted medication formularies, and similar issues tied to strategies for cost containment imposed by managed care organizations. In modernizing this guidance CEJA re-organized and consolidated content from multiple opinions to focus on relevant ethics issues, such as conflict of interest and physician professionalism. For example, Opinion 11.2.1, "Professionalism in Health Care Systems," identifies and consolidates guidance from five separate opinions to offer a succinct statement of conditions essential to promoting professionalism in care delivery systems.

For these reasons, the council concluded that in its present form the AMA *Code of Medical Ethics* appropriately addresses the fundamental concerns identified in the cited opinions of the TMA Board of Councilors.

RECOMMENDATION

Based on the foregoing considerations, the Council on Ethical and Judicial Affairs recommends that paragraph 2 of D-320.977, "Utilization Review, Medical Necessity Determination, Prior Authorization Decisions," be rescinded as having been accomplished and the remainder of this report be filed:

1. Our AMA will advocate: (a) for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and (b) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

~~2. Our AMA will request that the Council on Ethical and Judicial Affairs review current ethical opinions similar to the Texas Medical Association Board of Councilors opinions regarding medical necessity determination and utilization review.~~

2. ETHICAL PRINCIPLES FOR PHYSICIANS INVOLVED IN PRIVATE EQUITY OWNED PRACTICES

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

HOUSE ACTION: REFERRED

Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," instructs our American Medical Association (AMA) to

> study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices.

This report presents the fruits of deliberations by the Council on Ethical and Judicial Affairs (CEJA) on the need for ethics guidance in this area.

The council noted that current guidance in the AMA *Code of Medical Ethics (Code)* was developed initially to address issues raised by the advent of managed care. Reflecting on the respective challenges posed by managed care and private equity, the council concluded that where managed care organizations focused on goals of cost-containment and improving efficiency of care delivery rather than profitability per se, private equity/venture capital (PE/VC) investment in health care practices explicitly aims to enhance the profitability of any medical practice in which they invest during the period of their investment and further to realize significant profit when they divest of that practice after a term of years.

CEJA observed that House policy adopted in 2019 substantially accomplishes the goals sought by D-140.951. Council on Medical Service Report 11-A-19 carefully reviewed available data on the scope and impact of PE/VC investment in health care. Its recommendations were adopted as H-160.891, "Corporate Investors," which delineates 11 factors physicians should consider before entering into partnership with corporate investors, including issues of alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners. The AMA further developed and published materials to assist physicians contemplating partnering with PE/VC firms:

- Venture Capital and Private Equity: How to Evaluate Contractual Agreements
- Model Checklist: Venture Capital and Private Equity Investments
- Snapshot: Venture Capital and Private Equity Investments

In the council's view, the salient concerns raised by the engagement of PE/VC firms in health care, notably challenges to physicians' freedom to exercise professional judgment and strategies for reducing cost/enhancing profitability, are addressed in existing guidance in Opinions 11.2.1, "Professionalism in Health Care Systems"; 11.2.2, "Conflicts of Interest in Patient Care"; and 11.2.3, "Contracts to Deliver Health Care Services."

Given the existence of rich House policy on point and the fact that existing opinions in the *Code* substantially address key issues of concern, the council concluded that guidance specifically addressing PE/VC in health care is not the most effective response. Rather, the council believes that amending current guidance to more clearly encompass partnerships with PE/VC firms would best serve the interests of physicians and the patients they care for.

RECOMMENDATION

In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended as follows and the remainder of this report be filed:

> Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services physicians consider carefully the proposed contract to assure themselves that ~~the~~ its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests~~ do not obviously compromise their ability to fulfill their fiduciary obligations to patients.
>
> Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
>
> As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to ~~impede~~ put patients' interests at risk
>
> When ~~contracting~~ partnering with other entities to provide health care services, physicians should:
> (a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:
>
>   (i)   Minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance.
>
>   (ii)   Does not compromise physicians' own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk.
>
>   (iii)   Allows the physician to appropriately exercise professional judgment.
>
>   (iv)   Includes a mechanism to address grievances and supports advocacy on behalf of individual patients.
>
>   (v)   Permits disclosure to patients.
>
>   (vi)   Enables physicians to participate in, if not outright control, decisions about practice staffing.
>
> (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards.
>
> When physicians enter into arrangements with partners who may later sell the practice, physicians should seek explicit commitments that subsequent partners will sustain fidelity to patients and respect physicians' professional ethical obligations.

(Modify HOD policy)

3. SHORT-TERM MEDICAL SERVICE TRIPS

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

HOUSE ACTION: REFFERED

Short-term medical service trips send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks. They have been promoted, in part, as a strategy for addressing global health inequities, and have unquestionably 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 ensure significant benefits, 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.

Ethics guidance can neither redress historical wrongs nor solve the underlying structural issues that drive medical need in resource-limited settings. However, by making explicit the conditions under which short-term medical service trips are ethically sound and 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. In addition, ethics guidance can highlight the ways in which power imbalances and neo-colonial assumptions can shape these practices and so may undermine their moral acceptability. 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 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 the goals of building one's resume, improving one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [2].

A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including "short-term medical volunteerism" [5], "short-term medical missions" [6], "short-term medical service trips" [7,8], "short-term experience in global health" [9,10], "global health field experience" [11], "global health experience," and "international health experience"[2].

The Council on Ethical and Judicial Affairs prefers "short-term medical service trips." This term is clear, concrete, concise, and does not easily lend itself to multiple interpretations or misunderstanding. It also 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 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 the 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 will often include medications, procedures or tools with which volunteers are not familiar. As such, global health and limited-resource medicine should be considered a unique area of expertise, requiring specific background and training to practice effectively [12].

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. They "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 [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should recognize that it is a privilege to practice and train in vulnerable communities, and that justice requires reciprocity and equal respect among local and expatriate staff, community members, and patients in this context [9].

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.

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

Emerging guidelines identify the following ethical duties for participants of short-term medical service trips and organizations sponsoring them: (a) to produce good clinical outcomes, (b) to promote justice and sustainability, (c) to minimize burdens on host communities, and (d) to respect persons and local cultures [2,9,10,11].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their 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 embedded in a longer-term strategy and collaboratively planned with the host community [7,10].

Minimizing 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 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 other, less visible 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. 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 storage and distribution burdens for the local health care

system and jeopardize development by the local community of effective solutions to long-term supply problems [7]. Likewise, the expectation that local healthcare and support staff will be available to assist visiting clinicians in addition to (or in place of) their usual duties can disrupt care for their existing patients. It should not be assumed that host communities can absorb additional costs, even on a temporary basis [14]. Particular attention should be paid to the follow-up care that burdens local practitioners and may result in harm to patients in the aftermath of invasive procedures [15].

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 reveal possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map onto 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, such as resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Others involve successfully 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 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]. Further, trip participants should be mindful that they bring with them their own unexamined cultural beliefs and assumptions about lower income countries, some of which trace back to colonialist, racialized attitudes. For instance, there is a widespread assumption that visiting physicians and trainees possess universally applicable (and unmistakably superior) skills and knowledge by virtue of their association with Western biomedicine [19].

Individuals do not bear these responsibilities alone. 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 [16]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect carefully before reaching such a decision [17].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, 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" even though this is far from a universal practice [9,cf. 2,12]. Collaborative planning can identify what material resources and clinical skills volunteers should be expected to bring to the effort. For example, what activities volunteers should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [11].

Supervision of trainees also needs to be explicitly arranged and followed up once they reach the field. Studies show that 20% of participants reported inadequate supervision during their trips, and it is common for medical schools to allow "students to arrange experiences abroad without faculty supervision and support" [18, 12]. Allowing students to practice in limited-resource settings without proper supervision is a clear violation of their fiduciary duty.

Thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, the goal of supporting capacity building in the local community calls for participants who have "training and/or familiarity with principles of international development, social determinants of health, …public health systems" and in some cases, health care administration [10,12]. Without this background, interventions may result in "resource wasting and potentially poorer patient care" [12].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally important, to contribute effectively and minimize "culture shock" and distress, volunteers need a basic understanding of the context in which they will be working [1,2,7]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [7]. They also need to know to whom they can turn for guidance. If at all possible, this should be someone from outside the host community, since community members may be reluctant to "push back" against the judgments and actions of volunteers [19].

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the real possibility that physicians and trainees will encounter situations in which they "are unable to act in ways that are consistent with ethics and their professional values" or "feel complicit in a moral wrong" [9]. In particular, volunteers will be required to assess "how to balance risks and benefits [for very poor and medically vulnerable patients they would not normally encounter] … how to distribute limited medical resources, and when non-intervention is the appropriate choice" [15]. In addition, volunteers may find that local biases are inconsistent with their own commitments to equity and non-discrimination. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. Physicians under stress due to difficult ethical situations experience emotional harm and this may, in turn, affect the quality of patient care [12]. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [9,10,11]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, [10]. Volunteers should strive to avoid working with "volunteer placement organizations" that operate primarily for their own profit and/or lack adequate on-site supervision for trainees [14]. Such organizations exploit the needs of host communities by offering them a small sum per volunteer and then sending volunteers to them without support. Physicians and

trainees should also refrain from the "casual or opportunistic" treatment of patients that are not coordinated with local health care systems in advance [20].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program outcomes should be appropriate to the program's goals as defined proactively in collaboration with the host community [9]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [7]. Since the success of procedures and programs cannot reasonably be verified if even their medium-term outcomes cannot be monitored, participants should prefer programs that can track patient results over an extended timeframe, even if their own contribution is made in a short time.

RECOMMENDATION

In light of these considerations, 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. 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 prioritize 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 or the sponsoring organization.

(b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting volunteers, but also possible adverse effects the presence of volunteers could have for beneficial local practices and practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources that help them to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise

of conscience. Volunteers should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and volunteers' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, so that they can provide safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable for practice in their home country, even if the host country's standards are more flexible or less rigorously enforced.

(f) Ensure appropriate supervision of trainees, consistent with their training in their home countries, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in resource-limited settings.

(g) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

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4. RESPONSIBILITIES TO PROMOTE EQUITABLE CARE

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

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                       REMAINDER OF REPORT FILED

The disproportionate impact of the COVID-19 pandemic on minoritized and marginalized communities harshly illuminated ongoing inequities in health care across the globe. In the U.S., the pandemic lent new energy to calls for change within and outside medicine and health care. Even as the American Medical Association (AMA) drew on the *Code of Medical Ethics* as a key resource during this public health crisis, the Council on Ethical and Judicial Affairs recognized that additional guidance is needed to explicitly address the ethical implications of social forces that drive how and to whom health care is provided. What role, that is, should physicians and health care institutions play as agents for change in the face of manifest inequity?

Looking critically at the *Code,* the council observed that existing guidance does indeed speak to matters of fairness or justice in health care. Principle IX of the *AMA Principles of Medical Ethics* enjoins physicians to "support access to care for all people." Opinions variously enjoin physicians to promote access to care and address financial barriers to care; to avoid discriminating against or exploiting patients and research participants; to be prudent stewards of health care resources in the interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria; even to ensure that organs and tissues for transplantation are treated as a national rather than a regional or local resource. (Appendix A.)

At the same time, the council recognized that, for the most part, guidance in the *Code* focuses narrowly on the conduct of individual physicians in their interactions with individual patients. By presenting guidance that addresses the manifestations of inequitable care, not the root causes, the *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of individuals. Yet medicine has long understood that social factors play a critical role in health status and health disparities.

Such an individualist approach further fails to realize that the social drivers of health have deep and powerful histories. While important and necessary, it is not sufficient to remind physicians of their professional ethical obligations not to discriminate against patients based on explicit and continuously evolving "protected categories" of civil rights law. A professional responsibility to promote equitable care calls for situated, historically informed social and political knowledge of a sort that physicians are not specifically trained in, however, and on forms of discernment and self-reflection on which ethics guidance is generally silent.

This report by the Council on Ethical and Judicial Affairs seeks to explore more thoughtfully the joint responsibilities that physicians as individual professionals and health care institutions as sites of service have to ensure that all patients in their practices and communities receive "safe, effective, patient centered, timely, efficient, and equitable care."[Opinion 1.1.6]

FOUNDATIONAL ETHICS

At its core, the *Code* rests on an understanding of medicine as inherently a moral activity, rooted in the encounter between "someone who is ill, on the one hand, and someone who professes to heal, on the other," in the words of physician and ethicist Edmund Pellegrino [1]. The "covenant of trust" established in such encounters binds physicians in a duty of fidelity to patients. The *Code* enjoins physicians, as medical professionals, to "dedicate themselves to providing competent medical care and respect for human dignity and rights."[Principle I] Doing so

encompasses a responsibility for physicians to "examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect their judgment."[Opinion 8.5] Competent physicians "cultivate continuous self-awareness and self-observation," and strive to "be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest."[Opinion 8.13]

Together these commitments entail physicians' responsibility to become attentive to how their own perceptions, attitudes, and assumptions can color how they interact with different patients and to take steps to ensure that in delivering care their behavior as individuals neither privileges some patients nor disadvantages others.

It is also the case that "clinical medicine is the final pathway through which public policies ultimately come to affect the lives of sick persons" [2]. Although Pellegrino had in mind the specific example of managed care as the public policy in question, his observation holds more broadly. Physicians' duty of fidelity also encompasses the responsibility to recognize and address the ways in which the policies and practices of health care institutions shape patients' experience of health, illness, and care.

SHIFTING PERSPECTIVE: FROM "CULTURAL COMPETENCE" TO "STRUCTURAL COMPETENCE"

Training physicians for "cultural competence" has been promoted as a way to ensure that physicians take account of non-medical dimensions of health and illness, with the ultimate goal of promoting robust respect for patient autonomy and improving quality of care. By learning how to recognize "cross-cultural expressions of illness and health," the thinking has been, physicians would "be able to counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation or other markers of difference" [3]. Yet as the physician anthropologist Arthur Kleinman noted, "culture" is not reducible to a technical skill in which clinicians can develop expertise [4]. Moreover, "cultural factors are not always central to a case, and might actually hinder a more practical understanding of an episode [of illness]."

Patients' health status, outcomes, and experiences of care are shaped significantly by social, economic, and political drivers unrelated to cultural understandings of illness and healing [3,5]. To make meaningful progress in achieving equitable care, physicians must recognize how "the pathologies of social systems impact the material realities of their patients' lives" [3]. As the pathologist Rudolf Virchow noted more than a century ago, "If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society" [5]?

Truly to address their patients' health needs, physicians must acquire skills, not of cultural competence, but of "structural competence." That is:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "noncompliance," trauma, psychosis) also represent downstream implications of a number of upstream decisions, about matters such as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of health and illness [3,6].

ADDRESSING INEQUITY, PROMOTING EQUITABLE CARE[1]

Public health expert Camara Jones observed that when people think about "racism" they think of "personally mediated racism": the expression of prejudice and discrimination based on "differential assumptions about the abilities, motives, and intentions of others" and "differential actions toward others according to their race" [7]. Personally mediated racism may be intentional or unintentional, manifest in acts of commission and acts of omission. Jones distinguishes this from "institutional racism," that is, "differential access to goods, services, and opportunities of society by race." Institutionalized racism, she notes, is structural, "codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator."

Fulfilling the ethical responsibility to promote equitable care, then, requires that medicine address inequity and discrimination not only at the level of personal interactions among physicians and patients, but equally at the

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[1] See Appendix B for selected resources for individuals and institutions.

institutional level in the policies and practices that structure interactions within an institution's walls and in the institution's interactions with the community (communities) beyond its walls.

Personal Interactions

Physicians individually cannot be expected to repair structural discrimination and inequity in health care on their own, but they *can* hold themselves accountable for the ways in which their own interactions with patients, families, and fellow health care personnel may contribute to perpetuating discrimination and inequity. Doing so requires that physicians cultivate awareness of how they perceive others, how they speak about or describe persons and medical conditions, and how they approach interactions with patients and others one on one. As first steps, they must address in their own behaviors and implicit biases, such as the use of stigmatizing language and habits of discrediting patients' knowledge and reports of illness. So too, adopting a trauma-informed care approach can help physicians recognize and address the medical and psychosocial effects for patients of persistent marginalization and discrimination.

Implicit bias. In its 2003 report, *Unequal Treatment,* the Institute of Medicine linked health care professionals' implicit bias—that is, bias, prejudices, and stereotypes that are not consciously held or recognized—to health disparities [8]. Subsequent research has confirmed that in health care, bias is "negatively associated with both care satisfaction and provider trust among racial/ethnic minority patients" [9]. Among African American patients, for example, physicians' implicit bias has been shown to be a "relatively consistent predictor of ethnic/racial differences in patients' subjective experiences with their health care providers" [10].

Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question [10], but learning to recognize one's own biases offers a point of entry for cultivating the awareness and critical self-reflection required of physicians as medical professionals. The most effective training will affirm learners' egalitarian goals and commitment and go beyond raising awareness to teach how to control implicit bias, using active learning techniques that enable learners to practice new skills [10]. Training to "replace negative nonverbal or paraverbal behaviors with positive communication behaviors" can be a practical, attainable way to improve health outcomes [11].

Stigmatizing language. How physicians and other health care personnel speak to and about patients conveys multiple messages, intended and otherwise. Languages that "others" patients, "blames" them for their illness, or casts them as dangerous or threatening can influence care in the moment and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14]; Diabetes Australia likewise draws attention to problematic language used about diabetes [15]. Phrasing that suggests negative attitudes toward patients, questions patients' credibility, conveys disapproval of patients, or stereotypes them by race or social class captured in the medical record can undermine care [13]. By the same token, complimenting patients, offering patient-centered accounts of health behaviors that minimizes blame, and incorporating into the record details that personalize the patient as an individual can foster less discriminatory, more effective interactions [13].

Language that calls into question patients' credibility or their ability to report their experience of illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients as knowers based on physicians' expectations, explicit or implicit, about what information is relevant and meaningful for the health care encounter. It privileges a biomedical model of disease over patients' culturally and socially informed explanatory models and lived experience of illness [4], at times in ways that may actually be harmful to patients when marginalizing their reports of illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care [17]. Epistemic injustice may be both more common and more likely to be harmful for patients whose conditions are poorly understood or contested biomedically—as has been the case with chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient's contribution to the encounter, physicians undermine trust and the opportunity to create an effective therapeutic relationship.

Trauma-informed practice. Adopting a trauma-informed approach to care offers further opportunity for physicians and other health care professionals to promote equitable care. Trauma-informed care recognizes that trauma "has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [18]. "Trauma" encompasses more than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat, for example [19]. It also acknowledges the impact of social, economic, and political

structures that cause harm to individuals and communities captured in Paul Farmer's concept of "structural violence" [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

Suggestions for implementing trauma-informed care focus on patient-centered communication practices, understanding the effects of trauma, interprofessional collaboration, understanding how one's own experience of trauma may influence interactions with patients, and specific screening for trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient's past; rather, it offers a way to help improve patients' function and well-being in the present [23].

Institutional Policies and Practices

Health care institutions share in medicine's fundamental commitment of fidelity to patients. Institutions are the physical and social settings of medical practice, constellations of resources and relationships established to enable the provision of care. Indeed, health care only happens in and through institutions. They reflect the attitudes of clinical professionals, administrators, and society even as they help to form the attitudes of practitioners and shape the delivery of care. In contemporary health care, institutions are the primary medium by which health care interacts with the political, economic, and social structures of society and the major means by which care is delivered. They too bear the ethical responsibilities of medicine.

The policies and practices of health care institutions importantly determine what care choices are available to patients and physicians. Regardless of size, physician practices, hospitals, and other institutions share responsibility to promote equitable access and care for all. What an institution chooses to know about its patients and staff and how that information factors into institutional decision making and patterns of practice can play a significant role in whether or to what extent the institution promotes equitable care across the board.

Social drivers of health. Just as how physicians perceive, speak about, and interact with others can perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what information the institution captures about the patients it serves, how it does so, how that information is available to clinicians for treatment purposes, and how (or whether) it informs institutional operations. The foundational "explanatory model" of allopathic medicine—to borrow Kleinman's terminology again—grounds diagnosis and treatment jointly in biological function and personal health behaviors, despite ample evidence that social factors powerfully influence health and the delivery of health care [3,20,24].

Recognition of the significant health impact of structural factors has led to calls to rethink the social history to capture information beyond questions about tobacco or alcohol use to glean information about the socioeconomic and political realities of patients' lives.[25]. For example, initiatives at Brigham & Women's Health and Massachusetts General Hospital have expanded history taking to gather information about patients' particular life circumstances, emotional health, perceptions of health care, and health-related behaviors, as well as access to and utilization of health care [26]. Other institutions have deployed tools to assess patients' "structural vulnerability," including whether someone has money to pay for rent, food, and utilities; a safe, stable place to sleep; friends, family, or others who can provide help when needed; or has experienced discrimination [27,28].

Some health care institutions have gone beyond collecting data to intervene directly to address the extra-medical factors that so deeply affect health through initiatives to promote income security, medical-legal partnerships to help patients address legal issues that impinge on health status, and clinic-based child literacy programs among others [29,30].

Race-based versus race-conscious tools. As CEJA noted in its 2021 informational report on augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S. helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when it grounds research and clinical practice in notions of race as unproblematically a genetic, biological characteristic of patients rather than a socially mediated classification of persons [31,32]. A growing body of evidence demonstrates that race-adjusted practices, intended to improve care, are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and machine learning tools intended to support prediction of risk or diagnosis [33,34].

Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the category of race (/ethnicity) is, as a proxy measure it does indirectly capture important information about the influence of

sociocultural, economic, environmental and genetic factors on health and health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race and ethnicity until better predictors become available [31]. Ensuring that when racial categories are used, they promote equitable health remains of the upmost importance, however.

Aversive racism. How institutions interact with and treat their staff and affiliated personnel can also perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and promoting personnel can reflect aversive racism, "which results from the interplay of … social dominance, implicit bias, and in-group favoritism" [35]. Aversive racism is reflected in laments about lack of qualified candidates from historically minoritized communities; it attributes an individual's inability to thrive within an organization to their personal characteristics or behaviors; and it buys into the "myth of meritocracy" that sees success as a function of ability while ignoring the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender concordance between patient and physician improves patient satisfaction with care and health outcomes, fostering and respecting diversity among health care personnel can be a path toward promoting more equitable care.

Equity, safety, and quality improvement. As a species of "wicked problem," a term first introduced in the realm of urban planning [36], inequitable care doesn't lend itself to a simple, one-time solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there is "significant disagreement [among stakeholders] about the nature and cause of the problem and . . . potential solutions" [37]. By their nature, wicked problems cannot be solved by individual action but must be addressed at the organizational or systems level. To address ongoing inequities in care, institutions must first acknowledge that such inequities exist—they must ensure that they have compendious information about patients and leverage that information to understand where and how change needs to be made. For example, studies show that African American patients with heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn't apparent without further exploration. A retrospective study at Brigham & Women's Health found that patients who receive care in a cardiology unit rather than on a medical ward have better outcomes, and that African American and Latinx patients were less frequently admitted to cardiology from the emergency department, as were women, suggesting an institutional pattern that may contribute to disparate outcomes [38].

Health care institutions in fact already have models on hand that can be adapted to promote equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity initiatives can focus on redesigning the processes and systems that perpetuate discrimination and inequity. In both realms, well-designed initiatives:

> balance [a] systems approach with individual accountability. Both recognize the role of cognitive, often subconscious biases in contributing to unintentional harm. Both highlight the importance of psychological safety to support difficult conversations. And both avoid excessive focus on individual or interpersonal blame. The goal isn't to shame individual clinicians but to build resilient systems around them that support optimal behaviors [39].

ADVOCATING FOR CHANGE

For both individual health care professionals and for health care institutions, the commitment to serve patients in need entails obligations to examine prevailing attitudes, habits, policies, and practices that determine what care is available to whom and to take steps to remove or re-engineer obstacles that undermine the ability to ensure equitable care for all.

Physicians have a responsibility to recognize that despite ongoing change in health care and seeming erosion of their authority they *do* have power within their institutions, and to use their voice and status to advocate for change. They have a responsibility to help create opportunities in which to raise challenging issues, to argue for tools to enable difficult conversations, and to develop relationships within their institutions to support one another. Ultimately, physicians have a responsibility to thoughtfully and constructively identify and begin to address the formal and informal expectations that create barriers to equitable care for their patients and equitable treatment of those who provide care and support caregiving within the health care institution.

Health care institutions have a responsibility to foster change within their walls, and to acknowledge the multiple roles they play in their communities. Health care institutions are deeply embedded in the life of their communities beyond their role in delivering care—they are employers, purchasers of goods and services, property owners, and civic leadership. A growing number of institutions recognize that as "anchor institutions" within their communities

they can—and should—be agents for positive change. As member institutions of the Healthcare Anchor Network observe,

> Hospitals and health systems are critical local economic engines and mission-driven organizations inextricably linked to the long-term well-being of those we serve—because of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more active role in supporting our local economies. We have an opportunity and obligation to improve health and well-being outcomes in the communities we serve and confront economic and social instability in our nation that remain obstacles to that goal [40].

The Institute for Healthcare Improvement's Pursuing Equity Initiative identifies five strategies institutions should adopt to eliminate racism—and other forms of discrimination—in health care:

- Understanding the context of racism and other forms of oppression among the communities in which the institution is located;
- Normalizing discussion of oppression and listening to stakeholders to understand their experience;
- Meaningfully promoting workforce diversity;
- Developing and implementing business practices and policies through an equity lens;
- Adopting data systems that identify and track equity gaps in clinical outcomes;
- Using quality improvement strategies to narrow equity gaps and improve health care for all [41].

RECOMMENDATION

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

> Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The "covenant of trust" established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients' experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

> Enduring health disparities across patient populations challenge these duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.

> In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:

> a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;
> b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;
> c) Use the social history to capture information about non-medical factors that affect a patient's health status and access to care to inform their relationships with patients and the care they provide.

> Within their institutions, as professionals with unique knowledge, skill, experience, and status, physicians should collaborate with colleagues to promote change. They should:

> d) Support one another in creating opportunities for critical reflection across the institution;
> e) Identify institutional policies and practices that perpetuate or create barriers to equitable care;

    f)   Participate in designing and supporting well-considered strategies for change to ensure equitable care for all.

As institutions in and through which health care occurs, hospitals and other health care institutions share medicine's core values and commitment of fidelity, and with it ethical responsibility to promote equitable care for all. Moreover, as entities that occupy positions of power and privilege within their communities, health care institutions are uniquely positioned to be agents for change. They should:

    g)   Support efforts within the institution to identify and change institutional policies and practices that may perpetuate or create barriers to equitable care;
    h)   Engage stakeholders to understand the histories of the communities they serve and recognize local drivers of inequities in health and health care;
    i)   Identify opportunities and adopt strategies to leverage their status within the community to minimize conditions of living that contribute to adverse health status.

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APPENDIX A - EXISTING GUIDANCE ON JUSTICE

	Promote access/ address barriers to care	Do not discriminate	Do not exploit	Distribute benefits fairly	Distribute burdens fairly	Be prudent stewards of shared resources	Advocate for patients	Promote equitable care
Principle VII	X						X	
Principle IX	X							
1.1.2 Prospective patients		X				X		
1.1.6 Quality								X
1.1.7 Physician exercise of conscience		X						
1.1.8 Physician responsibilities for safe patient discharge		X				X	X	
6.2.1 Guidelines for organ transplantation from deceased donors	X	X				X		
6.2.2 Directed donation of organs for transplantation	X			X				
7.1.3 Study design and sampling		X			X			
7.3.2 Research on emergency medical interventions					X			
7.3.3 International research	X		X	X	X			
7.3.10 Expanded access to investigational therapies			x					
8.5 Disparities in health care	X	X		X				
8.11 Health promotion and disease prevention	X							
11.1.1 Defining basic health care	X		X		X		X	
11.1.2 Physician stewardship of health care resources	X						X	
11.1.3 Allocating limited health care resources			X		X	X		
11.1.4 Financial barriers to health care access	X							X
11.2.5 Retainer practices	X							
11.2.6 Mergers of secular and religiously affiliated health care institutions	X							X

APPENDIX B - SELECTED SAMPLE RESOURCES

Racial and Health Equity: Concrete STEPS for Smaller Practices
https://edhub.ama-assn.org/steps-forward/module/2782426?resultClick=1&bypassSolrId=J_2782426

National Institutes of Health – Implicit Bias Training Course
https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course

American Academy of Family Physicians – Implicit Bias Resources
https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html

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National Institute on Drug Abuse – Words Matter
https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Temple Health – Reduce Stigmatizing Language in Healthcare

https://www.templehealth.org/for-physicians/reduce-stigmatizing-language

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Indiana University – Trauma-Informed Care Professional Development Certificate
https://rural.indiana.edu/impact/health/trauma-informed-care-certificate.html

Texas Department of Family and Protective Services – Trauma-Informed Care Training
https://www.dfps.texas.gov/Training/Trauma_Informed_Care/default.asp

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Centers for Medicare and Medicaid – Accountable Health Communities
Health-Related Social Needs Screening Tool
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

American Academy of Family Physicians – Social Needs Screening Tool (Short Form)
https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
https://prapare.org/

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Racial and Health Equity: Concrete STEPS for Health Systems
https://edhub.ama-assn.org/steps-forward/module/2788862?resultClick=1&bypassSolrId=J_2788862

AMA – Advancing Equity Through Quality and Safety Peer Network
https://www.ama-assn.org/about/ama-center-health-equity/ama-advancing-equity-through-quality-and-safety-peer-network

Anchor Mission Playbook – prepared by Rush University
https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf

Institute for Healthcare Improvement – Pursuing Equity Learning and Action Network
https://www.ihi.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx

5. CEJA'S SUNSET REVIEW OF 2013 HOUSE POLICIES

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

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                        REMAINDER OF REPORT FILED

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

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

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

(e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

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

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

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

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

RECOMMENDATION

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

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-480.974	Professionalism in Telemedicine and Telehealth	The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate. (BOT Rep. 22, A-13)	Rescind; Directive was fulfilled by issuance of Opinion 1.2.12 – "Ethical Practice in Telemedicine".
H-185.937	Reproductive Parity	Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care. (Res. 4, I-13)	Retain; remains relevant.
H-245.984	Treatment Decisions for Seriously Ill Newborns	Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmed: CEJA Rep. 4, A-13)	Retain; remains relevant.
H-25.999	Health Care for Older Patients	The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new	Retain; remains relevant.

		challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.. (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-11; Appended: Res. 709, A-13)	
H-295.865	Discrimination Against Patients by Medical Students	Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (Res. 1, A-13)	Retain; remains relevant.
H-450.942	Patient Adherence to Treatment Plans	It is AMA policy that patient adherence to any medical treatment program is necessary in order to achieve high quality and cost-effective health care. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-478.988	Data Ownership and Access to Clinical Data in Health Information Exchanges	1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures.	Retain; remains relevant.

		3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13; CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 4, I-13)	
H-5.989	Freedom of Communication Between Physicians and Patients	It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)	Retain; remains relevant.
H-520.998	Medical Neutrality	Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-525.981	Discrimination of Women Physicians in	The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and	Retain; remains relevant.

	Hospital Locker Facilities	equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	

6. USE OF DE-IDENTIFIED PATIENT INFORMATION (D-315.969)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-315.969, "Research Handling of De-Identified Patient Data," adopted in November 2021 directs the Council on Ethical and Judicial Affairs (CEJA) to "consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data."

This informational report summarizes CEJA's research and deliberations to date and direction of further inquiry.

DO YOU KNOW WHERE YOUR PATIENTS' DATA ARE TONIGHT?

An extraordinary variety of data are now regularly collected by multiple entities and stakeholders, for multiple—and potentially discrepant—purposes:

> The last few decades have witnessed the creation of novel ways to produce, store, and analyse data, culminating in the emergence of the field of data science, which brings together computational, algorithmic, statistical and mathematical techniques towards extrapolating knowledge from big data. . . . The availability of vast amounts of data in machine-readable formats provides an incentive to create efficient procedures to collect, organise, visualise and model these data. . . . Researchers across all disciplines see the newfound ability to link and cross-reference data from diverse sources as improving the accuracy and predictive power of scientific findings and helping to identify future directions of inquiry, thus ultimately providing a novel starting point for empirical investigation [1].

As one scholar has noted, in this new data landscape "it is almost impossible to perform most daily activities without revealing personal information and providing fodder for data brokers and big data organizations, whether they are public or private" [2]. Data that in themselves are not traditionally categorized as "medical" or "health related" can still yield information about health status—for example, predictive analysis of data about customers' purchases enabled Target "to identify about 25 products that, when analyzed together, allowed the company to assign each shopper a "pregnancy prediction" score, and even to predict the shopper's due date [3].

The ease with which data from multiple sources within and outside medicine can now be linked and cross-referenced significantly exacerbates challenges of protecting patient privacy and the confidentiality of health information. The council has come to recognize that it should extend its analysis beyond research use of patient information to questions of what role physicians and health care institutions can and should play in protecting patients' interests in how their information is shared and used more broadly.

WHY PROTECT PRIVACY/CONFIDENTIALITY?

Within the *Code,* Opinion 3.1.1, "Privacy in Health Care," distinguishes four aspects of privacy:

> personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

The *Code* does not explicitly examine whether personal medical or health information are ethically distinct from other kinds of personal information (e.g., financial records) or in what way. Current guidance treats the importance of protecting privacy in all its forms as self-evident, holding that respecting privacy in all its aspects is of fundamental importance, "an expression of respect for autonomy and a prerequisite for trust" (Opinion 3.1.1).

In the context of information technology, van den Hoven identifies the following concerns with respect to protecting personal data (medical or other):

- Prevention of harm
- Commodification of and asymmetry in power to control personal information
- Informational injustice and discrimination
- Encroachment on moral autonomy and human dignity [4]

Price and Cohen observe that violations of privacy can result in both harm—tangible negative consequences, such as discrimination in insurance or employment or identity theft—and in wrongs that occur from the fact of personal information being known without the subject's awareness, even if the subject suffers no tangible harm:

> One may be wronged by a privacy breach even if one has not been harmed. For example, suppose that an organization unscrupulously or inadvertently gains access to data you store on your smart phone as part of a larger data dragnet. After reviewing it, including photos you have taken of an embarrassing personal ailment, the organization realizes your data is valueless to them and destroys the record. You never find out this happened. Those reviewing your data live abroad and will never encounter you or anyone who knows you. It
> is hard to say you have been harmed in a consequentialist sense, but many think the loss of
> control over your data, the invasion, is itself ethically problematic even absent harm [5].

They further note that privacy issues can arise not only when data are known, but when data mining enables others to "generate knowledge about individuals through the process of inference rather than direct observation or access" [5]. Recall the anecdote above about Target inferring customers' current health status from data of their purchases over time.

STRATEGIES FOR PROTECTING PRIVACY/CONFIDENTIALITY

In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints on the sharing of "protected health information" contained in the medical record—including in the context of relationships within the limited domain of "covered entities" defined in the Act, such as physicians, hospitals, pharmacies, and third-party payers. HIPAA does not cover certain other health-relevant data, especially data generated voluntarily by patients themselves, for example, through the use of health-related apps on devices such as Fitbit or Apple Watch, let alone identifiable data individuals provide to municipal authorities, utilities, or retailers. Information that began in the medical record can take on a new, independent life when linked with personal information widely available through datasets generated outside of health care.

The current state of data science challenges the prevailing procedural model for protecting privacy: informed consent and de-identification. Yet as Barocas and Nissenbaum have observed, many continue to see these "as the best and only workable solutions for coping with privacy hazards. They do not deny the practical challenges, but their solution is to try harder—to develop more sophisticated mathematical and statistical techniques and new ways of furnishing notice . . ." [6].

That is, solutions have tended to take the form of technical solutions to enable captured data to be shared, such as the creation of synthetic datasets that replace some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical properties and relationships among variables of interest [7,8]. Alternative responses have taken the form of proposals for new models of informed consent, such as "blanket consent" (permission to use without restriction), [9] "broad consent" (consent for an unspecified range of future research subject to content or process restrictions), [6,10,11] and "dynamic consent" (the use of personalized, digital interface between participants and researchers that allows participants to "tailor and manage their own consent preferences" over time) [12,13].

The Problem of Re-Identification

Whether de-identifying datasets truly prevents individual data subjects from being re-identified is increasingly called into question. Removing the 18 identifiers specified in HIPAA can no longer ensure that the data subject cannot be re-identified by triangulation with identifying information from other readily available datasets [14]. The development of ever more robust statistical strategies for de-identifying data in turn prompts the development of yet more robust strategies to enable re-identification [15,16].

The creation of "synthetic" datasets seeks to offer a technical solution that will enable research with large datasets while protecting privacy by replacing some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical relationships among variables of interest [17,18]. Inspired by models in manufacturing and engineering, medical "digital twins"—AI technologies that simulate organs or tissues in real time and in relation to an identifiable patient—are proffered as tools to enable highly personalized predictive medicine for the patient whose data have been "twinned" [19,20].

AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

Barocas and Nissenbaum contend that "even if [prevailing forms of consent and anonymization] were achievable, they would be ineffective against the novel threats to privacy posed by big data." [6] A more effective option, Nissenbaum has argued, would understand privacy protection as a function of "contextual integrity," i.e., that in a given social domain information flows conform to the context-specific informational norms of that domain. Whether a transmission of information is appropriate depends on "the type of information in question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints under which this transmission takes place" [21].

Nissenbaum goes on to note that novel information flows, such as those enabled by contemporary data science, should be assessed in reference to how they affect the interests of key parties and whether the distribution of associated benefits, risks, and costs among parties is fair in terms of who enjoys the benefits and who endures the costs. Further, appropriate information flows serve "not merely the interests of individual information subjects, but also contextual, social ends and values—for example, whether information flows with health care achieve the ends and purposes of health care and sustain the values associated with health care.

An evaluative framework proposed by Nissenbaum and colleagues focuses on components of dataset creation and use:

- Creation of the dataset—sourcing, assembling, cleaning, assigning labels [1]
- Composition—properties of the dataset (content, mappings among data elements expressed in different modalities) and attributes of the dataset (e.g., demographic representativeness)
- Distribution—how the dataset is made available, terms of use, disclaimers
- Purpose—what the data set is for, its intended uses, the purposes for which it is optimized [22]

Nissenbaum and colleagues identify ethical values associated with these components, including privacy, autonomy, and the moral legitimacy of the purpose a dataset is created to serve, as well as issues of bias, equity, and accountability, among others.

This approach has much in common with AMA analysis of conditions for trustworthy augmented intelligence in medicine [23] and offers a starting point for thinking about how CEJA might approach recommendations for ethically responsible management of patient information for purposes of both clinical care and biomedical research.

MOVING FORWARD

Against this backdrop the council looks forward to continuing its deliberations and to presenting its analysis and recommendations at a future meeting of the House of Delegates.

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7. USE OF SOCIAL MEDIA FOR PRODUCT PROMOTION AND COMPENSATION (RESOLUTION 025-A-22)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At its 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution 025), "Use of Social Media for Product Promotion and Compensation," which asked that the American Medical Association (AMA) "study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain."

Over the course of its deliberations, the Council on Ethical and Judicial Affairs (CEJA) has identified several relevant issues. These include the volatile and dynamic nature of social media and the fact social media users are able to present themselves as a product, promoting themselves and/or attempting to influence others. At issue as well are the distinctive notions of professionalism attached to the profession of medicine and how they impact individuals and physician integrity; and ethical differences among different promotional activities, e.g., whether the products or

services sold or promoted health- or non-health related and whether they are marketed to patients or the general public.

The AMA *Code of Ethics* has existing relevant guidance: Opinions 9.6.4, "Sale of Health-Related Products," and 9.6.5, "Sale of Non-Health-Related Goods," as well as Opinion 2.3.2, "Professionalism in the Use of Social Media." The Council will continue to review existing guidance in contemplation of the relevant issues identified above and anticipates submitting a report to the House of Delegates at a subsequent meeting.

8. JUDICIAL FUNCTION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS – ANNUAL REPORT

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

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

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

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2022 – MARCH 31, 2023

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
4	**Determinations of no probable cause**
18	**Determinations following a plenary hearing**
33	**Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing**

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
9	**No sanction or other type of action**
2	**Monitoring**
14	**Probation**
1	**Revocation**
6	**Suspension**
2	**Denied**
1	**Suspension lifted**
4	**Censure**
12	**Reprimand**
4	**Admonish**

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