

Reference Committee on Amendments to Constitution and Bylaws

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**Contained in the Handbook Addendum*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-23

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the
2 applications of the American Academy of Addiction Psychiatry, American Society for Aesthetic
3 Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance for national medical
4 specialty organization representation in the American Medical Association (AMA) House of
5 Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and
6 presented to the SSS Assembly for consideration.

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

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

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

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

21
22 Review of the materials and discussion during the SSS meeting at the November 2022 Interim
23 Meeting indicated that the American Academy of Addiction Psychiatry, American Society for
24 Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance meet the criteria
25 for representation in the HOD.

26 27 RECOMMENDATION

28
29 Therefore, the Board of Trustees recommend that the American Academy of Addiction Psychiatry,
30 American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic
31 Resonance be granted representation in the AMA House of Delegates and that the remainder of the
32 report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX
Exhibit A

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

National Medical Specialty Societies

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

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

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

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Addiction Psychiatry	384 of 1,127 (34%)
American Society for Aesthetic Plastic Surgery	359 of 1,691 (21%)
Society for Cardiovascular Magnetic Resonance	254 of 866 (30%)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-23

Subject: National Cancer Research Patient Identifier

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Resolution 021-A-22, “National Cancer Research Identifier,” sponsored by the Mississippi
2 Delegation, was referred by the House of Delegates. Resolution 021-A-22 asks our AMA to
3 establish:

4
5 “[The] National Cancer Research Identifier (NCRI) [...] to improve care for patients with
6 cancer.”
7

8 The NCRI as described would be overseen by a nonprofit entity, and the role of the NCRI would be
9 to collect identifying patient information to create:

10
11 “a privacy-ensuring, unique cancer research identifier [that] could travel with the anonymous
12 fragments of medical information currently collected by large databases, and therefore allow
13 the fragments to be reunited into a complete, yet anonymous cancer journey that researchers
14 can study to improve care”.
15

16 The summary of testimony from A-22 acknowledges concerns regarding the creation of the NCRI
17 and recommends Resolution 021 for referral. Testimony was strongly in support of referral, noting
18 the complexity of the issue, i.e., a national identifier may exclude some people from clinical trials,
19 may dissuade some people with privacy concerns from joining trials, may put undue burdens (e.g.,
20 further EHR responsibilities) on some physicians, and it may implicate privacy, trust, and
21 surveillance concerns. Testimony also noted concern about what organizations would be involved
22 in overseeing the NCRI process and questioned why the resolution should be limited to cancer
23 rather than be broader in scope.
24

25 BACKGROUND

26
27 In the US, all 50 states have laws that require newly diagnosed cancers to be reported to a central
28 cancer registry [1]. The CDC’s National Program of Cancer Registries (NPCR) and NCI’s
29 Surveillance, Epidemiology, and End Results (SEER) Program are the two primary central
30 registries that collect cancer incidence data in the US. Together, the NPCR and the SEER Program
31 collect data from the entire US population, and according to a 2017 joint report by the CDC and
32 NIH, the two comprehensive surveillance systems work collaboratively to collect, compile, and
33 disseminate information on more than 1.7 million cancer cases annually [2].

1 ALTERNATIVES TO NCRI

2
3 While Resolution 021-A-22 claims that the formation of the NCRI would “dramatically increase
4 the speed and power of real-world research” it is unclear if this would be the case. Using identified
5 data may in fact slow down the research process if the identified data are subject to the Common
6 Rule, which would require researchers using NCRI data to go through IRB approval. Furthermore,
7 as noted in BOT 16 N-21 “De-Identified Data” and Resolution 003-A-18 “Proposing Consent for
8 De-Identified Patient Information,” once data has been de-identified, HIPAA no longer applies,
9 which raises potential concerns if certain entities obtain access to the NCRI. This is particularly
10 troubling because of the unequal power between those whose data has been collected and those
11 who control that data, an issue that has been referred to as the “Big Data Divide” [3]. This is also a
12 threat to justice within clinical research, as data subjects from lower socioeconomic and/or
13 minority backgrounds tend to have even less control over their data and are thus more vulnerable to
14 misuse of their data [4].

15
16 Meanwhile current cancer research is clipping along at a steady pace. A 2020 report by Springer
17 Nature found that “[t]he number of cancer research articles published in journals listed in the
18 Nature Index increased by 25.8 percent between 2015 and 2019. This is four times the growth for
19 overall article output in this period” [5]. The report also found that the US’s National Cancer
20 Institute (NCI) “is by far the world’s biggest funder of cancer research” [5].

21
22 Supporting the NCRI’s data modernization efforts to move to modern cloud-based systems,
23 working to ensure that data collection is conducted in a just and equitable manner for all peoples,
24 and encouraging physicians to discuss opportunities with cancer patients about participating in
25 cancer research may be more appropriate avenues for our AMA to approach improving cancer
26 research instead of forming the NCRI.

27
28 Our AMA could also seek to promote data and code sharing in oncology research as an alternative
29 means of accomplishing the goal of Resolution 021. The practice of code sharing involves stating
30 explicitly, in text or supplementary material, in research publications if and where any or all data or
31 code underpinning the results is available for access. A recent research paper found that data and
32 code sharing occur infrequently in oncology despite the prevalence of mandatory sharing policies
33 outlined by publishers; additionally, there is a large gap between oncology researchers who declare
34 their data to be available, and those who actually archive data in a way that facilitates its reuse [6].

35 ETHICAL CONCERNS SURROUDING NCRI

36
37
38 The AMA’s *Code of Medical Ethics* does not explicitly prohibit such a patient identifier so long as
39 the body adheres to the Code’s opinions on protecting patient confidentiality, respecting patient
40 privacy, providing appropriate informed consent, and ensuring the data is used in a manner that
41 promotes justice (see [Opinion 3.2.1](#) Confidentiality; [Opinion 3.3.2](#) Confidentiality & Electronic
42 Medical Records; [Opinion 3.2.4](#) Access to Medical Records by Data Collection Companies;
43 [Opinion 4.1.3](#) Third-Party Access to Genetic Information; [Opinion 3.1.1](#) Privacy in Health Care;
44 [Opinion 7.3.7](#) Safeguards in the Use of DNA Databanks; [Opinion 2.1.1](#) Informed Consent; [Opinion](#)
45 [7.1.2](#) Informed Consent in Research; [Opinion 8.5](#) Disparities in Health Care).

46
47 However, Policy [H-315.962](#) “Research Handling of De-Identified Patient Information” states,
48 “[o]ur AMA supports efforts to promote transparency in the use of de-identified patient data and to
49 protect patient privacy by developing methods of, and technologies for, de-identification of patient
50 information that reduce the risk of re-identification of such information.” The collection and use of
51 identified patient data pose several concerns as even de-identified data do not eliminate the risk of

1 re-identification that can potentially harm patients. The Board observes the Council on Ethical and
2 Judicial Affairs is in the process of reviewing existing ethics guidance on the use of patient
3 information in research.

4
5 CONCLUSION

6
7 For these reasons, the Board concludes that the creation of a national cancer patient research
8 identifier is neither necessary nor desirable. AMA resources might be better utilized to support data
9 modernization efforts by existing cancer registries, work to ensure that no groups face barriers to
10 data collection efforts, encourage physicians to educate and engage patients to participate in
11 existing cancer research, and urge cancer researchers to improve data and code sharing.

12
13 RECOMENDATIONS

14
15 In light of these considerations, your Board of Trustees recommends that the following be adopted
16 in lieu of Resolution 021, A-22, "National Cancer Research Patient Identifier," and the remainder
17 of this report be filed:

18
19 Our AMA encourages greater use of code and data sharing to enhance the timely conduct of
20 research in oncology and implementation of innovations in care.

Fiscal Note: Minimal – less than \$500

REFERENCES

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4. Reed-Brendt, R., E. S. Dove, and M. Pareek, on behalf of the UK-REACH Study Collaborative Group. The Ethical Implications of Big Data Research in Public Health: “Big Data Ethics by Design” in the UK-REACH Study. *Ethics & Human Research*. 2022;44(1):2-7. doi:10.1002/eahr.500111.
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6. Hamilton, DG, Page, MJ, Finch, S. et al. How often do cancer researchers make their data and code available and what factors are associated with sharing?. *BMC Med*. 2022;20(438). doi.org/10.1186/s12916-022-02644-2.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-23

Subject: AMA Bylaws--Gender Neutral Language and Miscellaneous Update

Presented by: Kevin Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The AMA Constitution establishes the basic principles of our AMA and the AMA Bylaws provide
2 the framework for the governance and administration of the Association. Our AMA membership,
3 like the population of physicians practicing in the United States, has become increasingly diverse.
4 Language plays a major role in shaping culture and social attitudes and gender-neutral language
5 promotes gender equality and inclusivity and eradicates gender bias; thus, your Council believes
6 that the AMA Constitution and Bylaws should utilize gender-neutral language, and proposes
7 recommendations for Bylaw amendments for House consideration and action.

8
9 The *Merriam-Webster Dictionary* recognizes the word ‘they’ as a singular pronoun, and the *AP*
10 *Manual of Style* states that “they/them/their is acceptable in limited cases as a singular and-or
11 gender-neutral pronoun, when alternative wording is overly awkward or clumsy.” Lastly, the *AMA*
12 *Manual of Style* provides the following guidance: “Avoid sex-specific pronouns in cases in which
13 sex specificity is irrelevant. Do not use common-gender “pronouns” (eg, “s/he,” “shem,” “shim”).
14 Reword the sentence to use a singular or plural non–sex-specific pronoun, neutral noun equivalent,
15 or change of voice; or use “he or she” (“him or her,” “his or her[s],” “they or their[s]”). The use of
16 the “singular they” construction is permitted when rewriting would be awkward or unclear.”

17
18 It also should be noted that where Bylaw language is included in the Internal Operating Procedures
19 (IOPs) of an AMA section or in the Rules of an AMA Council, those documents will be similarly
20 modified. All sections are or will be modifying their IOPs to make these gender-neutral.

21
22 Lastly, there is one other proposed change unrelated to gender-neutrality in 7.4.1, which defines the
23 membership of the Organized Medical Staff Section (OMSS). The change in wording from “Active
24 resident and fellows who have been ~~selected~~ certified by their medical staffs as representatives to
25 the Business Meeting also shall be considered members of the Section,” mirrors the language in the
26 OMSS IOPs and accurately reflects OMSS practice.

27 28 RECOMMENDATIONS

29
30 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
31 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative
32 vote of two-thirds of the members of the House of Delegates present and voting.

1 **2—House of Delegates**

2
3 ****

4
5 **2.8 Alternate Delegates.**

6
7 ***

8
9 **2.8.6 Status.** The alternate delegate is not a “member of the House of Delegates” as that
10 term is used in these Bylaws. Accordingly, an alternate delegate may not introduce
11 resolutions into the House of Delegates, nor vote in any election conducted by the House
12 of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or
13 Vice Speaker of the House of Delegates. The alternate delegate must immediately
14 relinquish ~~his or her~~ their position on the floor of the House of Delegates upon the request
15 of the delegate for whom the alternate delegate is substituting.
16

17 **3—Officers**

18
19 ***

20
21 **3.4 Elections.**

22
23 ***

24 **3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee shall be listed
25 alphabetically on a single ballot. Each elector shall have as many votes as the number of
26 Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall
27 be counted if it contains fewer or more votes than the number of Trustees to be elected, or
28 if the ballot contains more than one vote for any nominee. A nominee shall be elected if
29 they ~~he or she~~ ~~has~~ have received a vote on a majority of the legal ballots cast and ~~is~~ are one
30 of the nominees receiving the largest number of votes within the number of Trustees to be
31 elected.
32

33
34 ***

35 **3.5 Terms and Tenure.**

36
37 ***

38
39 **3.5.7.1 Limitations.** No candidate shall be eligible for election or re-election as the young
40 physician trustee unless, at the time of election, ~~he or she is~~ they are under 40 years of age
41 or within the first eight years of practice after residency and fellowship training, and ~~is~~ are
42 not a resident/fellow physician. A young physician trustee shall be eligible to serve on the
43 Board of Trustees for the full term for which elected, even if during that term the trustee
44 reaches 40 years of age or completes the eighth year of practice after residency and
45 fellowship training.
46

47
48 ***

49 **3.8 Installation of Officers.** The officers of the AMA shall assume their duties at the close of
50 the meeting at which they are elected, except as stated herein. The medical student trustee shall
51 assume office at the close of the Annual Meeting following the Interim Meeting at which the

medical student trustee was elected. If elected at an Interim Meeting or Special Meeting, the public trustee shall assume office at the close of the Annual Meeting following ~~his or her~~ their election. If elected at an Annual Meeting, the public trustee shall assume office at the close of the Annual Meeting at which ~~he or she~~ was elected.

6—Councils

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

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

7—Sections

7.4 Organized Medical Staff Section.

7.4.1 Membership. Membership in the Section shall be open to all active physician members of the AMA who are members of a medical staff of a hospital or a medical staff of a group of practicing physicians organized to provide healthcare. Active resident and fellow members of the AMA who are ~~selected~~ certified by their medical staffs as representatives to the Business Meeting also shall be considered members of the Section.

7.4.2 Representatives to the Business Meeting. Each medical staff of a hospital and each medical staff of a group of practicing physicians organized to provide healthcare may select up to two active physician AMA member representatives to the Business Meeting. The president or chief of staff of a medical staff may also attend the Business Meeting as a representative if ~~he or she is~~ they are an active physician member of the AMA. The representatives must be physician members of the medical staff of a hospital or group of practicing physicians organized to provide healthcare or residents/fellows affiliated with the medical staff of a hospital or group of practicing physicians organized to provide healthcare. All representatives to the Business Meeting shall be properly certified in accordance with procedures established by the Governing Council and approved by the Board of Trustees.

1 **7.4.2.1** When a multi-hospital system and its component medical staffs have unified
2 the medical staffs, those medical staff members who hold specific privileges to practice
3 at each separate entity within the unified system may select up to two representatives
4 to the Business Meeting, so long as they are active physician members of the AMA.
5 The president or chief of staff of a unified medical staff also may attend the Business
6 Meeting as a representative if ~~he or she is~~ they are an active physician member of the
7 AMA.

8
9 ***

10
11 **7.7 Minority Affairs Section.**

12
13 ***

14
15 **7.7.3.1 Section Representatives on the Governing Council.** If a representative of the
16 Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases
17 to meet the criteria for membership in the section from which elected within 90 days prior
18 to the Annual Meeting, such member shall be permitted to serve in office until the
19 conclusion of the Annual Meeting in the calendar year in which ~~he or she~~ they ceases to
20 meet the membership requirement of the respective section.

21
22 **7.7.3.2 Section Representative as Immediate Past Chair.** A Section representative who
23 has been elected as chair of the Governing Council, but who ceases to meet the criteria for
24 membership in the section from which elected during ~~his or her~~ their term as Immediate
25 Past Chair, shall be permitted to complete the term of office, as long as the officer remains
26 an active physician member of the AMA.

27
28 ***

29
30 **7.10 Women Physicians Section.**

31
32 ***

33
34 **7.10.3.1 Section Representatives on the Governing Council.** If a representative of the
35 Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases
36 to meet the criteria for membership in the section from which elected within 90 days prior
37 to the Annual Meeting, such member shall be permitted to serve in office until the
38 conclusion of the Annual Meeting in the calendar year in which ~~she or he~~ they ceases to
39 meet the membership requirement of the respective section.

40
41 (Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-23

Subject: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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.

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

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.~~

(Modify HOD policy)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-23

Subject: Ethical Principles for Physicians Involved in Private Equity Owned Practices

Presented by: Peter A Schwartz, MD, Chair MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

[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.

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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:

- 1 (a) Carefully review the terms of proposed contracts or have a representative do so on
2 their behalf to assure themselves that the arrangement:
3
4 (i) Minimizes conflict of interest with respect to proposed reimbursement
5 mechanisms, financial or performance incentives, restrictions on care or other
6 mechanisms intended to influence physicians' treatment recommendations or
7 direct what care patients receive, in keeping with ethics guidance.
8
9 (ii) Does not compromise physicians' own financial well-being or ability to provide
10 high-quality care through unrealistic expectations regarding utilization of services
11 or terms that expose the physician to excessive financial risk.
12
13 (iii) Allows the physician to appropriately exercise professional judgment.
14
15 (iv) Includes a mechanism to address grievances and supports advocacy on behalf of
16 individual patients.
17
18 (v) Permits disclosure to patients.
19
20 (vi) Enables physicians to participate in, if not outright control, decisions about
21 practice staffing.
22

- 23 (b) Negotiate modification or removal of any terms that unduly compromise physicians'
24 ability to uphold ethical standards.
25

26 When physicians enter into arrangements with partners who may later sell the practice,
27 physicians should seek explicit commitments that subsequent partners will sustain
28 fidelity to patients and respect physicians' professional ethical obligations.
29

30 (Modify HOD policy)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-A-23

Subject: Short-Term Medical Service Trips

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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].

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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

1 short-term medical service trips requires diligent preparation on the part of participants and
2 sponsors in collaboration with host communities.

3
4 Physicians and trainees who are involved with short-term medical service trips should ensure that
5 the trips with which they are associated:

6
7 (a) Focus prominently on promoting justice and sustainability by collaborating with the host
8 community to define mission parameters, including identifying community needs, mission
9 goals, and how the volunteer medical team will integrate with local health care professionals
10 and the local health care system. In collaboration with the host community, short-term medical
11 service trips should prioritize efforts to support the community in building health care capacity.
12 Trips that also serve secondary goals, such as providing educational opportunities for trainees,
13 should prioritize benefits as defined by the host community over benefits to members of the
14 volunteer medical team or the sponsoring organization.

15
16 (b) Seek to proactively identify and minimize burdens the trip places on the host community,
17 including not only direct, material costs of hosting volunteers, but also possible adverse effects
18 the presence of volunteers could have for beneficial local practices and practitioners. Sponsors
19 and participants should ensure that team members practice only within their skill sets and
20 experience.

21
22 (c) Seek to become broadly knowledgeable about the communities in which they will work and
23 take advantage of resources that help them to cultivate the cultural sensitivity they will need to
24 provide safe, respectful, patient-centered care in the context of the specific host community.
25 Members of the volunteer medical team are expected to uphold the ethics standards of their
26 profession and volunteers should insist that strategies are in place to address ethical dilemmas
27 as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from
28 care of an individual patient or from the mission after careful consideration of the effect that
29 will have on the patient, the medical team, and the mission overall, in keeping with ethics
30 guidance on the exercise of conscience. Volunteers should be clear that they may be ethically
31 required to decline requests for treatment that cannot be provided safely and effectively due to
32 resource constraints.

33
34 Sponsors of short-term medical service trips should:

35
36 (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly
37 resources that cannot be assured locally. This includes arranging for local mentors, translation
38 services, and volunteers' personal health needs. It should not be assumed that host
39 communities can absorb additional costs, even on a temporary basis.

40
41 (e) Proactively define appropriate roles and permissible range of practice for members of the
42 volunteer team, so that they can provide safe, high-quality care in the host setting. Team
43 members should practice only within the limits of their training and skills in keeping with
44 professional standards they would deem acceptable for practice in their home country, even if
45 the host country's standards are more flexible or less rigorously enforced.

46
47 (f) Ensure appropriate supervision of trainees, consistent with their training in their home
48 countries, and make certain that they are only permitted to practice independently in ways
49 commensurate with their level of experience in resource-limited settings.

- 1 (g) Ensure a mechanism for meaningful data collection is in place, consistent with recognized
- 2 standards for the conduct of health services research and quality improvement activities in the
- 3 sponsor's country.
- 4
- 5 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS*

CEJA Report 04-A-23

Subject: Responsibilities to Promote Equitable Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

9
10 Looking critically at the *Code*, the council observed that existing guidance does indeed speak to
11 matters of fairness or justice in health care. [Principle IX](#) of the *AMA Principles of Medical Ethics*
12 enjoins physicians to “support access to care for all people.” Opinions variously enjoin physicians
13 to promote access to care and address financial barriers to care; to avoid discriminating against or
14 exploiting patients and research participants; to be prudent stewards of health care resources in the
15 interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria;
16 even to ensure that organs and tissues for transplantation are treated as a national rather than a
17 regional or local resource. (Appendix A.)

18
19 At the same time, the council recognized that, for the most part, guidance in the *Code* focuses
20 narrowly on the conduct of individual physicians in their interactions with individual patients. By
21 presenting guidance that addresses the manifestations of inequitable care, not the root causes, the
22 *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of
23 individuals. Yet medicine has long understood that social factors play a critical role in health status
24 and health disparities.

25
26 Such an individualist approach further fails to realize that the social drivers of health have deep and
27 powerful histories. While important and necessary, it is not sufficient to remind physicians of their
28 professional ethical obligations not to discriminate against patients based on explicit and
29 continuously evolving “protected categories” of civil rights law. A professional responsibility to
30 promote equitable care calls for situated, historically informed social and political knowledge of a
31 sort that physicians are not specifically trained in, however, and on forms of discernment and self-
32 reflection on which ethics guidance is generally silent.

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

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 CARE¹

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 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

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

1 shown to be a “relatively consistent predictor of ethnic/racial differences in patients’ subjective
2 experiences with their health care providers” [10].

3
4 Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question
5 [10], but learning to recognize one’s own biases offers a point of entry for cultivating the
6 awareness and critical self-reflection required of physicians as medical professionals. The most
7 effective training will affirm learners’ egalitarian goals and commitment and go beyond raising
8 awareness to teach how to control implicit bias, using active learning techniques that enable
9 learners to practice new skills [10]. Training to “replace negative nonverbal or paraverbal behaviors
10 with positive communication behaviors” can be a practical, attainable way to improve health
11 outcomes [11].

12
13 *Stigmatizing language.* How physicians and other health care personnel speak to and about patients
14 conveys multiple messages, intended and otherwise. Languages that “others” patients, “blames”
15 them for their illness, or casts them as dangerous or threatening can influence care in the moment
16 and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National
17 Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14];
18 Diabetes Australia likewise draws attention to problematic language used about diabetes [15].
19 Phrasing that suggests negative attitudes toward patients, questions patients’ credibility, conveys
20 disapproval of patients, or stereotypes them by race or social class captured in the medical record
21 can undermine care [13]. By the same token, complimenting patients, offering patient-centered
22 accounts of health behaviors that minimizes blame, and incorporating into the record details that
23 personalize the patient as an individual can foster less discriminatory, more effective interactions
24 [13].

25
26 Language that calls into question patients’ credibility or their ability to report their experience of
27 illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients
28 as knowers based on physicians’ expectations, explicit or implicit, about what information is
29 relevant and meaningful for the health care encounter. It privileges a biomedical model of disease
30 over patients’ culturally and socially informed explanatory models and lived experience of illness
31 [4], at times in ways that may actually be harmful to patients when marginalizing their reports of
32 illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care
33 [17]. Epistemic injustice may be both more common and more likely to be harmful for patients
34 whose conditions are poorly understood or contested biomedically—as has been the case with
35 chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient’s
36 contribution to the encounter, physicians undermine trust and the opportunity to create an effective
37 therapeutic relationship.

38
39 *Trauma-informed practice.* Adopting a trauma-informed approach to care offers further
40 opportunity for physicians and other health care professionals to promote equitable care. Trauma-
41 informed care recognizes that trauma “has lasting adverse effects on the individual’s functioning
42 and mental, physical, social, emotional, or spiritual well-being” [18]. “Trauma” encompasses more
43 than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat,
44 for example [19]. It also acknowledges the impact of social, economic, and political structures that
45 cause harm to individuals and communities captured in Paul Farmer’s concept of “structural
46 violence” [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

47
48 Suggestions for implementing trauma-informed care focus on patient-centered communication
49 practices, understanding the effects of trauma, interprofessional collaboration, understanding how
50 one’s own experience of trauma may influence interactions with patients, and specific screening for

1 trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient's
2 past; rather, it offers a way to help improve patients' function and well-being in the present [23].
3

4 *Institutional Policies and Practices*

5
6 Health care institutions share in medicine's fundamental commitment of fidelity to patients.
7 Institutions are the physical and social settings of medical practice, constellations of resources and
8 relationships established to enable the provision of care. Indeed, health care only happens in and
9 through institutions. They reflect the attitudes of clinical professionals, administrators, and society
10 even as they help to form the attitudes of practitioners and shape the delivery of care. In
11 contemporary health care, institutions are the primary medium by which health care interacts with
12 the political, economic, and social structures of society and the major means by which care is
13 delivered. They too bear the ethical responsibilities of medicine.
14

15 The policies and practices of health care institutions importantly determine what care choices are
16 available to patients and physicians. Regardless of size, physician practices, hospitals, and other
17 institutions share responsibility to promote equitable access and care for all. What an institution
18 chooses to know about its patients and staff and how that information factors into institutional
19 decision making and patterns of practice can play a significant role in whether or to what extent the
20 institution promotes equitable care across the board.
21

22 *Social drivers of health.* Just as how physicians perceive, speak about, and interact with others can
23 perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what
24 information the institution captures about the patients it serves, how it does so, how that
25 information is available to clinicians for treatment purposes, and how (or whether) it informs
26 institutional operations. The foundational "explanatory model" of allopathic medicine—to borrow
27 Kleinman's terminology again—grounds diagnosis and treatment jointly in biological function and
28 personal health behaviors, despite ample evidence that social factors powerfully influence health
29 and the delivery of health care [3,20,24].
30

31 Recognition of the significant health impact of structural factors has led to calls to rethink the
32 social history to capture information beyond questions about tobacco or alcohol use to glean
33 information about the socioeconomic and political realities of patients' lives.[25]. For example,
34 initiatives at Brigham & Women's Health and Massachusetts General Hospital have expanded
35 history taking to gather information about patients' particular life circumstances, emotional health,
36 perceptions of health care, and health-related behaviors, as well as access to and utilization of
37 health care [26]. Other institutions have deployed tools to assess patients' "structural
38 vulnerability," including whether someone has money to pay for rent, food, and utilities; a safe,
39 stable place to sleep; friends, family, or others who can provide help when needed; or has
40 experienced discrimination [27,28].
41

42 Some health care institutions have gone beyond collecting data to intervene directly to address the
43 extra-medical factors that so deeply affect health through initiatives to promote income security,
44 medical-legal partnerships to help patients address legal issues that impinge on health status, and
45 clinic-based child literacy programs among others [29,30].
46

47 *Race-based versus race-conscious tools.* As CEJA noted in its 2021 [informational report](#) on
48 augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S.
49 helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when
50 it grounds research and clinical practice in notions of race as unproblematically a genetic,
51 biological characteristic of patients rather than a socially mediated classification of persons [31,32].

1 A growing body of evidence demonstrates that race-adjusted practices, intended to improve care,
 2 are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and
 3 machine learning tools intended to support prediction of risk or diagnosis [33,34].
 4

5 Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the
 6 category of race (/ethnicity) is, as a proxy measure it does indirectly capture important information
 7 about the influence of sociocultural, economic, environmental and genetic factors on health and
 8 health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race
 9 and ethnicity until better predictors become available [31]. Ensuring that when racial categories are
 10 used, they promote equitable health remains of the utmost importance, however.
 11

12 *Aversive racism.* How institutions interact with and treat their staff and affiliated personnel can also
 13 perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and
 14 promoting personnel can reflect aversive racism, “which results from the interplay of ... social
 15 dominance, implicit bias, and in-group favoritism” [35]. Aversive racism is reflected in laments
 16 about lack of qualified candidates from historically minoritized communities; it attributes an
 17 individual’s inability to thrive within an organization to their personal characteristics or behaviors;
 18 and it buys into the “myth of meritocracy” that sees success as a function of ability while ignoring
 19 the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender
 20 concordance between patient and physician improves patient satisfaction with care and health
 21 outcomes, fostering and respecting diversity among health care personnel can be a path toward
 22 promoting more equitable care.
 23

24 *Equity, safety, and quality improvement.* As a species of “wicked problem,” a term first introduced
 25 in the realm of urban planning [36], inequitable care doesn’t lend itself to a simple, one-time
 26 solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there
 27 is “significant disagreement [among stakeholders] about the nature and cause of the problem and . .
 28 . potential solutions” [37]. By their nature, wicked problems cannot be solved by individual action
 29 but must be addressed at the organizational or systems level. To address ongoing inequities in care,
 30 institutions must first acknowledge that such inequities exist—they must ensure that they have
 31 compendious information about patients and leverage that information to understand where and
 32 how change needs to be made. For example, studies show that African American patients with
 33 heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn’t
 34 apparent without further exploration. A retrospective study at Brigham & Women’s Health found
 35 that patients who receive care in a cardiology unit rather than on a medical ward have better
 36 outcomes, and that African American and Latinx patients were less frequently admitted to
 37 cardiology from the emergency department, as were women, suggesting an institutional pattern that
 38 may contribute to disparate outcomes [38].
 39

40 Health care institutions in fact already have models on hand that can be adapted to promote
 41 equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity
 42 initiatives can focus on redesigning the processes and systems that perpetuate discrimination and
 43 inequity. In both realms, well-designed initiatives:
 44

45 balance [a] systems approach with individual accountability. Both recognize the role of
 46 cognitive, often subconscious biases in contributing to unintentional harm. Both highlight
 47 the importance of psychological safety to support difficult conversations. And both avoid
 48 excessive focus on individual or interpersonal blame. The goal isn’t to shame individual
 49 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.

(New HOD policy)

Fiscal Note: Less than \$500

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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>

⌘

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>

⌘

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

⌘

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/>

⌘

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.ihl.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx>

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-23

Subject: CEJA's Sunset Review of 2013 House Policies

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

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

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

1 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
2

3 6. Sunset policies will be retained in the AMA historical archives.
4

5 RECOMMENDATION

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

Fiscal Note: Less than \$500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
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 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)	Retain; remains relevant.
H-295.865	Discrimination Against Patients	Our AMA opposes the refusal by medical students to participate in the care of patients on	Retain; remains relevant.

	by Medical Students	the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (Res. 1, A-13)	
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	<p>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.</p> <p>2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures.</p> <p>3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice.</p> <p>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)</p>	Retain; remains relevant.
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;	Retain; remains relevant.

		<p>(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;</p> <p>(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and</p> <p>(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)</p>	
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 Hospital Locker Facilities	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 equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-23)

Introduced by: Medical Student Section

Subject: Opposing Mandated Reporting of LGBTQ+ Status

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Outing is defined as “exposing someone’s lesbian, gay, bisexual, transgender or gender non-binary identity to others without their permission”¹; and

Whereas, Mandatory reporting can “out” LGBTQ+ individuals and those questioning their sexual orientation and/or gender identity²; and

Whereas, Protection of LGBTQ+ and questioning individuals from being “outed” prevents additional physical safety risks, stress, mental health degradation, and discrimination^{3,4}; and

Whereas, There has been a recent wave of directives, resolutions, and laws in states such as Texas and Florida that require mandated reporters, including physicians, to disclose an individual’s gender identity and/or sexual orientation to outside entities^{5,6,7,8}; therefore be it

RESOLVED, That our American Medical Association amend Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” by addition to read as follows:

Opposing Mandated Reporting of People Who Question Their Gender Identity, H-65.959

Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation. (Modify Current Policy)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959

Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.

Citation: Res. 015, A-19;

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

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

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

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-23)

Introduced by: Medical Student Section

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Reports

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Patients of color often have worse healthcare outcomes than White patients,
2 particularly noticeable in the decreased life expectancies for Black and Indigenous patients^{1,2};
3 and
4

5 Whereas, Non-Hispanic White patients report lower satisfaction with their doctors, and patients
6 of color routinely report worse treatment and experiencing bias and racism when accessing
7 care^{1,3}; and
8

9 Whereas, Medical racism has been present throughout history and its legacy continues to
10 unfold today, manifesting as unethical experiments and substandard, unnecessary, or incorrect
11 treatments being given to minoritized racial groups historically and continuing to be discovered
12 even today^{4,5}; and
13

14 Whereas, The perpetuation of racial bias begins early in preclinical medical education, such as
15 when race is taught to be a biological factor or a substitute for education, income, or genetics,
16 which also deeply harms medical trainees from minoritized communities by perpetuating the
17 belief that their race makes them biologically different, unusual, or inferior^{6,7}; and
18

19 Whereas, A common example is that Black race is often used as a proxy for sickle cell trait or
20 disease, ignoring that sickle cell genetics can and do occur in people of any race, leading to
21 missed diagnoses in some individuals and also opening the possibility of “premature closure” in
22 diagnoses of Black patients experiencing symptoms that are similar to sickle cell but are
23 occurring due to a different pathological process^{7,8}; and
24

25 Whereas, Analyses of lecture slides and clinical vignettes used in medical education have found
26 that race or ethnicity is often presented as a biological risk factor or linked to certain behaviors,
27 without addressing social context or history⁹⁻¹¹; and
28

29 Whereas, During training, medical students learn to use race as a heuristic in preclinical exams
30 and on standardized licensing examinations, with a study of first- and second-year medical
31 students finding that all participants believed that if race was used in a board-style question, it
32 was likely relevant to answering the question correctly¹²⁻¹⁴; and
33

34 Whereas, A 2017 study of common USMLE Step 1 preparation material found that of 2,011
35 questions, 455 (20.6%) referred to race or ethnicity in the question stem, answer, or educational
36 objective, with 412 cases (90.5%) only mentioning it as a descriptor without a stated educational
37 objective, while the other 43 cases (9.45%) made race or ethnicity central to the case¹⁵; and
38

39 Whereas, It has been argued, including in the *AMA Journal of Ethics*, that race should (a) be
40 obtained as directly identified by the patient themselves and (b) be recorded in the social

history, rather than the first line in a case presentation, to help decrease the possibility of race being inappropriately used as a proxy while still recording this social factor as identified by the patient so that important social impacts like the patient's experiences with discrimination and racism can still be understood^{10,16-18}; and

Whereas, The American Medical Association has committed to recognizing and addressing the harmful effects of racism in medicine, medical training, and medical research (H-65.952, H-65.953, D-350.984, H-165.822, D-350.981); therefore be it

RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

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

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

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

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

Citation: Res. 11, I-20;

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

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

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

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health

needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21; Reaffirmed: CMS Rep. 5, A-22;

Racial Essentialism in Medicine D-350.981

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

Citation: Res. 10, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-23)

Introduced by: Medical Student Section

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship
Need Blind Model for Organ Procurement and Transplantation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Department of Homeland Security (DHS) estimates there were 11.4 million
2 undocumented immigrants in the United States as of 2018, 5,500 - 8,857 of whom are living
3 with end-stage renal disease (ESRD)¹⁻³; and
4

5 Whereas, Patients with ESRD who are citizens or, in some cases, documented non-citizens are
6 eligible for coverage through Medicare, but undocumented non-citizens are not eligible for these
7 benefits^{4,5}; and
8

9 Whereas, The cost of hemodialysis is exceptionally high, with a recent analysis suggesting a
10 cost of between \$40,000 - \$120,000 per year depending on the type of coverage⁶; and
11

12 Whereas, Undocumented immigrants who cannot afford the cost of maintenance hemodialysis
13 must rely on emergent-only hemodialysis after they develop life-threatening metabolic
14 disturbances, as the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates
15 that all states must provide federally funded emergency medical treatment irrespective of a
16 patient's ability to pay⁷; and
17

18 Whereas, California, New York, Illinois, Washington, and Colorado have passed laws that
19 recognize ESRD as an emergency medical condition, which allows Medicaid to be extended to
20 patients with ESRD for dialysis in outpatient clinics, but the remaining 45 US states do not have
21 similar exemptions⁸⁻¹²; and
22

23 Whereas, A cost-effective alternative approach to maintenance hemodialysis is kidney
24 transplantation¹³⁻¹⁵; and
25

26 Whereas, Current ethical and legal guidelines dictate that medical need alone should determine
27 how organs are allocated for transplant, including the AMA Code of Ethics 11.1.3, "Allocating
28 Limited Health Care Resources"; and
29

30 Whereas, Only 1% of all kidney transplant recipients per year are non-citizens, which is grossly
31 out of proportion to the 2-3% annual contribution to the donor organ pool made by this same
32 population, suggesting that citizenship status is adversely impacting the ability of noncitizens to
33 receive needed organs¹⁶; and
34

35 Whereas, While organs may be allocated to undocumented immigrants, current policy excludes
36 this patient population from receiving federal funding (and often state and local funding as a
37 result) to cover their transplantation and post-transplantation care^{5,17-19}; and

Whereas, Undocumented persons are not only often unable to afford potentially curative kidney transplants, they are also often unable to pay for costly post-transplant immunosuppressive medications, which may lead to graft failure over time²⁰; and

Whereas, Undocumented persons experience barriers to transplant eligibility for organs other than the kidneys, with a recent study of liver transplants indicating that undocumented persons rarely have access to liver transplantation and experience long wait times that can negatively affect outcomes in the transplant recipients²⁰⁻²³; and

Whereas, Each transplant center sets their own rules for organ waiting list eligibility, which may include financial status and insurance coverage alongside patient health and the presence of risk factors, thus reducing the likelihood of accessing an organ transplant for undocumented immigrants and legally present noncitizens who are uninsured²⁴; and

Whereas, The United Network for Organ Sharing (UNOS) is a private non-profit that contracts with the federal government to oversee the Organ Procurement Transplant Network (OPTN), which manages and maintains a national registry for organ matching in the US²⁵⁻²⁷; and

Whereas, Data from the United Network for Organ Sharing (UNOS) shows that from 2013-2018, heart and lung transplant outcomes were equivalent to or even better among non-citizens compared to citizens at one year, showing that citizenship status does not adversely impact transplant outcomes²⁸; and

Whereas, The OPTN collects voluntary data on citizenship status for both organ donors and recipients for two main purposes: first, to study the contribution of non-US citizens/non-US residents to the organ transplantation network in the US, and second, to monitor transplant centers to prevent medical transplant tourism, which is a widely condemned and often exploitative practice wherein wealthy patients travel abroad to purchase or obtain organs from poorer donors that can impinge on a host country's ability to provide for the transplant needs of its own population^{29,30}; and

Whereas, Current OPTN policy states that a candidate's citizenship or residency status should not be considered when making decisions about organ allocation³¹; therefore be it

RESOLVED, That our American Medical Association support initiatives that decrease financial and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients, regardless of immigration status, excluding medical tourism as defined in the AMA Code of Ethics 1.2.13 (New HOD Policy); and be it further

RESOLVED, That our AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status (Directive to Take Action); and be it further

RESOLVED, That our AMA amend H-370.982 by addition to read as follows:

**Ethical Considerations in the Allocation of Organ and Other
Scarce Medical Resources Among Patients, H-370.982**

Our AMA has adopted the following guidelines as policy:

(1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount

1 of resources required for successful treatment. In general, only very
2 substantial differences among patients are ethically relevant; the greater the
3 disparities, the more justified the use of these criteria becomes. In making
4 quality of life judgments, patients should first be prioritized so that death or
5 extremely poor outcomes are avoided; then, patients should be prioritized
6 according to change in quality of life, but only when there are very
7 substantial differences among patients. (b) Research should be pursued to
8 increase knowledge of outcomes and thereby improve the accuracy of these
9 criteria. (c) Non-medical criteria, such as ability to pay, social worth,
10 immigration status, perceived obstacles to treatment or follow-up, patient
11 contribution to illness, or past use of resources should not be considered.
12 (2) Allocation decisions should respect the individuality of patients and the
13 particulars of individual cases as much as possible. (a) All candidates for
14 treatment must be fully considered according to ethically appropriate criteria
15 relating to medical need, as defined in Guideline 1. (b) When very
16 substantial differences do not exist among potential recipients of treatment
17 on the basis of these criteria, a "first-come-first-served" approach or some
18 other equal opportunity mechanism should be employed to make final
19 allocation decisions. (c) Though there are several ethically acceptable
20 strategies for implementing these criteria, no single strategy is ethically
21 mandated. Acceptable approaches include a three-tiered system, a minimal
22 threshold approach, and a weighted formula.
23 (3) Decision making mechanisms should be objective, flexible, and
24 consistent to ensure that all patients are treated equally. The nature of the
25 physician-patient relationship entails that physicians of patients competing
26 for a scarce resource must remain advocates for their patients, and
27 therefore should not make the actual allocation decisions.
28 (4) Patients must be informed by their physicians of allocation criteria and
29 procedures, as well as their chances of receiving access to scarce
30 resources. This information should be in addition to all the customary
31 information regarding the risks, benefits, and alternatives to any medical
32 procedure. Patients denied access to resources have the right to be
33 informed of the reasoning behind the decision.
34 (5) The allocation procedures of institutions controlling scarce resources
35 should be disclosed to the public as well as subject to regular peer review
36 from the medical profession.
37 (6) Physicians should continue to look for innovative ways to increase the
38 availability of and access to scarce medical resources so that, as much as
39 possible, beneficial treatments can be provided to all who need them.
40 (7) Physicians should accept their responsibility to promote awareness of
41 the importance of an increase in the organ donor pool using all available
42 means. (Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

Citation: CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12; Reaffirmed: CEJA Rep. 4, A-22;

E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician's primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.

Physicians who participate in transplantation of organs from deceased donors should:

(a) Avoid actual or perceived conflicts of interest by ensuring that:

(i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;

(ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.

(b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.

(c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.

(d) Ensure that the prospective recipient (or the recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.

(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.

(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.

(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

Issued: 2016

E-1.2.13 Medical Tourism

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large.

Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient's decision to seek health care abroad. (IV, V, VI)

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.

(b) Advocate for education for health care professionals about medical tourism.

(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.

(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual's concerns and wishes about care.

(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.

(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.

(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.

(i) Offer their best professional guidance about a patient's decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to

obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.

(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician's prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:

- (i) the nature and duration of the patient-physician relationship;
- (ii) the likely impact on the individual patient's well-being;
- (iii) the burden declining to provide follow-up care may impose on fellow professionals;
- (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

Issued: 2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Considering sex, which is assigned at birth, and gender, which is how an individual
2 identifies, are necessary to provide personalized care to patients^{1,2}; and
3

4 Whereas, The importance of understanding sex and gender differences in clinical medicine was
5 recognized and agreed upon by the 103rd Congress of the United States via the passage of the
6 National Institutes of Health (NIH) Revitalization Act of 1993, which mandated that NIH-funded
7 clinical trials include women and minoritized populations as participants, and evaluate outcomes
8 by sex and race or ethnicity^{3,4}; and
9

10 Whereas, Recent studies have revealed that the NIH Revitalization Act of 1993 has not resulted
11 in significant increases in reporting results by sex, race, or ethnicity⁴⁻⁶; and
12

13 Whereas, Published randomized controlled trials frequently lack adequate enrollment of women
14 and sexual and gender minority participants, and fail to stratify of outcomes by sex or gender⁶⁻⁸;
15 and
16

17 Whereas, In a study of 215 leading surgery journals, only 6.7% of editors were women⁹; and
18

19 Whereas, The lack of diversity in sex and gender among authors, editors, peer reviewers, and
20 others involved in the review process for articles increases the threat of implicit bias affecting
21 the editorial review process⁹; and
22

23 Whereas, A study evaluating whether the sex of research participants influenced the
24 recommendation to publish an article revealed that "reviewers were almost twice as likely to
25 recommend publication for research conducted in men than the same research conducted in
26 women"¹⁰; and
27

28 Whereas, Following the conduction of an internal audits of their peer-review process to self-
29 monitor whether a gender bias or other biases impeding inclusivity existed amongst their
30 journals, the American Geophysical Union encouraged other publishers and societies to
31 conduct similar audits to establish a baseline for measuring progress and to promote
32 accountability¹¹; and
33

34 Whereas, Public access to medical research can promote collaboration between researchers
35 and help patients make informed decisions about their health^{12,13}; and
36

37 Whereas, There is a lack of harmonized, sex-disaggregated and gender-disaggregated
38 statistics available to both the research community and the general public^{6,10}; and

1 Whereas, Even when sex-disaggregated and gender-disaggregated data or clinical practice
2 guidelines are published, patients, physicians, community-based researchers, and research-
3 scientists will often remain unaware of their existence, as the resources fail to use sex-specific
4 and gender-specific terminology necessary to be cached by search engines⁷; and
5

6 Whereas, The United States federal government has demonstrated its capacity to support
7 efforts to provide centralized access to sex-stratified and gender-stratified data for patients,
8 physicians, and researchers via the establishment of digital repositories and publicly
9 downloadable databases by the National Institute of Diabetes and Digestive and Kidney
10 Diseases (NIDDK), National Center for Biotechnology Information, National Hospital Ambulatory
11 Medical Care Survey, and National Hospital Ambulatory Medical Care Survey^{15,16}; and
12

13 Whereas, In a Listening Session with transgender adults organized by the Food and Drug
14 Administration (FDA), respondents unanimously expressed enthusiasm towards “being part of
15 registry to collect information about surgical and medical treatment”^{16,17}; and
16

17 Whereas, These federal projects have developed and maintained confidentiality standards and
18 protocols that have protected patient privacy to date^{16,18}; and
19

20 Whereas, Despite the passage of the NIH Revitalization Act of 1993, only 3 of the 22 medical
21 devices that the Food and Drug Administration (FDA) deemed “highest risk” or “novel” from
22 2014 to 2017 provided subgroup analysis for both effectiveness and safety or both sensitivity
23 and selectivity for gender, race, and age¹⁹; and
24

25 Whereas, Clinical guidance criteria for implantable cardioverter defibrillators use, a device
26 subject to FDA approval, is based on clinical trials comprised of less than 30% females, and in
27 which evidence of safety and effectiveness is much stronger in males²⁰; and
28

29 Whereas, FDA studies that do not account for sex and gender may be ineffective or even
30 harmful to women, and sexual and gender minorities’ patients, as illustrated by an FDA study of
31 the LUTONIX drug-coated balloon catheter device, in which there was an increased
32 effectiveness in the total population primarily attributed to male patients, while female patients
33 had significantly worse outcomes with 51% effectiveness in bladder control compared to 70% in
34 the control group¹⁹; and
35

36 Whereas, Women experience twice as many adverse drug reactions as men due to possible
37 overmedication, with one study showing 88% of evaluated FDA-approved drugs had altered
38 drug pharmacokinetic profiles leading to higher blood concentrations and elevated elimination
39 times in women than in men, and 96% of evaluated drugs with higher pharmacokinetic values in
40 women than men had a higher incidence of adverse drug reactions in women²¹; and
41

42 Whereas, Current medication labeling practices maintain a binary conception of gender, which
43 has impeded sexual and gender minority patients from obtaining necessary medication¹⁷;
44 therefore be it
45

46 RESOLVED, That our American Medical Association facilitate the inclusion of women and
47 sexual and gender minority participants in clinical research studies and reporting of how the sex
48 and gender of these participants influenced study outcomes requires the cooperation of
49 researchers, federal agencies, and journal editors, by amending Policy H-525.988, “Sex and
50 Gender Differences in Medical Research,” by addition and deletion to read as follows:

Sex and Gender Differences in Medical Research, H-525.988

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; ~~and~~
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative-;
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities;
and
(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

An Expanded Definition of Women's Health H-525.976

Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

Citation: CSAPH Rep. 05, A-16;

Comparative Effectiveness Research H-460.909

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

Citation: CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09; Reaffirmation I-10; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 4, I-19;

Mitigating Gender Bias in Medical Research H-460.891

Our AMA will advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process.

Citation: Res. 610, A-19;

Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research H-460.911

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial

accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Citation: Res. 005, A-18;

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

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

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

E-9.5.5 Gender Discrimination in Medicine

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

(a) Promote fairness in the workplace, including providing for:

(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;

(ii) on-site child care services for dependent children;

(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.

(b) Promote fairness in academic medical settings by:

(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;

(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;

(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;

(iv) structuring the mentoring process through a fair and visible system.

(c) Take steps to mitigate gender bias in research and publication.

Issued: 2016

Alzheimer's Disease H-25.991

Our AMA:

- (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
- (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
- (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
- (4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
- (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
- (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
- (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-23)

Introduced by: Medical Student Section

Subject: Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, There is a lack of inclusivity in the hospital and operating rooms when it comes to the
2 availability of modest professional uniforms and hospital gowns^{1,2}; and
3

4 Whereas, Wearing modest or hijab-compliant professional attire is religiously obligatory for
5 Muslim women observing hijab and a critical part of Muslim identity³; and
6

7 Whereas, Members of the medical care team or other patients who do not identify as Muslims
8 may also want to wear more modest clothing, due to spiritual, personal, or even medical
9 reasons; and
10

11 Whereas, Certain practicing Mormons, Amish, Orthodox Jews, and Christians use modest
12 apparel⁴; and
13

14 Whereas, A 2020 study found that 4.5% of the total US physician workforce consists of
15 physicians who are international medical graduates of Muslim-majority nations, and this number
16 does not include Muslim physicians born in the United States so the total number of US Muslim
17 physicians is likely higher⁵; and
18

19 Whereas, The Institute for Social Policy and Understanding's (ISPU) *American Muslim Poll*
20 *2022: A Politics and Pandemic Status Report* found that Muslims were the most likely religious
21 group to experience discrimination in institutional settings, especially when seeking healthcare
22 services⁶; and
23

24 Whereas, A national survey of American Muslim physicians in 2013 found that 24% of Muslims
25 surveyed experience religious discrimination on the job⁷; and
26

27 Whereas, There are many accounts of hijab-wearing Muslim women who state that their
28 medical duties are hindered due to a lack of modest attire, such as wearing an N-95 respirator
29 over a hijab⁸; and
30

31 Whereas, Modest or 'halal' scrub options and medical hijabs exist, but are not laundered by
32 hospitals or supplied by hospital-approved third parties, and therefore are not allowed into the
33 operating room per hospital policy⁸⁻¹⁰; and
34

35 Whereas, A 2018 study found wearing long sleeves while prepping a patient in the operating
36 room decreases airborne contaminants¹¹; and

1 Whereas, The Association of Perioperative Registered Nurses (AORN) released guidelines in
2 2015 that require individuals who are scrubbed to wear long-sleeves in the operating room¹²;
3 and
4

5 Whereas, Despite concerns that long-sleeves can cause increased surgical site infections, a
6 study found that the implementation of AORN's guidelines about wearing long-sleeves in the
7 operating room did not affect the frequency of surgical site infections¹³; and
8

9 Whereas, A 2021 systematic review of 59 articles from 2000-2019 found no correlation between
10 what was worn in the operating room and the incidence of surgical site infections¹⁴; and
11

12 Whereas, A 2021 systematic review found that research studying the association between
13 clothing in the operating room and surgical site infections is lacking, despite guidelines like
14 those of AORN's that stipulate operating room attire requirements¹⁴; and
15

16 Whereas, The U.S. Equal Employment Opportunity Commission states, "...employers are
17 required by federal law to make exceptions to their usual rules or references to permit
18 employees to observe religious dress and grooming practices," and that hospitals with restrictive
19 policies could be liable for denial of accommodation without evidence that religious garb and
20 grooming pose a workplace risk or hazard¹⁵; and
21

22 Whereas, Modest, hospital-provided scrubs can serve as professional, clean and functional
23 attire⁸; and
24

25 Whereas, According to OSHA, personal protective equipment (PPE) is any equipment that is
26 worn by an individual whose purpose is to protect against exposures to hazardous materials
27 that can cause bodily harm in the workplace¹⁶; and
28

29 Whereas, According to OSHA, PPE should "fit comfortably, encouraging worker use" but hijab
30 observers often need to sacrifice comfort and ease of access for modesty^{9,16}; and
31

32 Whereas, According to OSHA, scrubs are considered "street clothing", not PPE, and therefore
33 should be covered under gowns, aprons, and laboratory coats in the operating room¹⁷; and
34

35 Whereas, Before entering the operating room at most institutions, scrubs must be covered by an
36 additional sterile gown after a healthcare provider properly scrubs in, covering anything they
37 may be wearing below, including hospital laundered scrubs¹⁸; and
38

39 Whereas, The American Hospital Association promotes the enhancement of cultural
40 competency because cultural competency is recognized as an essential means of reducing
41 racial and ethnic disparities in health care¹⁹; and
42

43 Whereas, Cultural competence is defined as the ability of providers and organizations to
44 effectively deliver health care services that meet the social, cultural, and linguistic needs of
45 patients^{20,21}; and
46

47 Whereas, Cultural competence in the healthcare setting includes incorporating culture-specific
48 attitudes and values into health promotion tools and willingness to make clinical settings more
49 accessible to patients^{20,21}; and

Whereas, Lack of cultural competence may lead to patient dissatisfaction^{20,21}; and

Whereas, Hospitals should provide modest scrubs for employees and hospital attire options for patients as well to promote cultural and religious inclusivity^{2,6}; and

Whereas, Some patients require modesty in interactions and in clothing during clinical encounters and procedures^{2,22}; and

Whereas, Failure to provide modest accommodations for patients who require it is a predictor of delayed healthcare in certain patient populations²³; and

Whereas, One approach of the AMA's 2021-2023 Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity is to build alliances and share power with physicians and stakeholders who have been historically marginalized & minoritized to "develop structures and processes to consistently center [their] experiences and ideas"²⁴; and

Whereas, Policy H-440.856 states that the AMA encourages all physicians to wear clean, appropriate attire, and research into textile transmission of infections²⁵; and

Whereas, Policy H-440.810 states that the AMA encourages diverse PPE designs to fit all healthcare professional's body types, cultural expressions, and practices, but this policy fails to consider the religious obligations of modesty that some may follow and the fact that scrubs are not considered PPE according to OSHA²⁶; and

Whereas, Policy H-65.949 states that the AMA encourages healthcare institutions to provide PPE that takes both patient safety and healthcare worker's natural hair/hairstyles or cultural headwear into account, but does not explicitly state whether this applies to religious and cultural modest clothing²⁷; therefore be it

RESOLVED, That our American Medical Association support the provision of safe, culturally and religiously sensitive operating room scrubs and hospital attire options for both patients and employees. (New HOD Policy)

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

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RELEVANT AMA POLICY

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.

6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

Citation: Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21;

Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949

Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.

Citation: Res. 006, A-22;

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856

Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.

Citation: BOT Rep. 3, A-10; Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Ensuring Privacy as Large Retail Settings Enter Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Large retail settings such as Amazon, CVS, Dollar General, Target, and Wal-Mart are in the process of moving into the provision of general and mental healthcare; and

Whereas, Concerns have been raised by medical providers about the business models, role of medical professionals, and quality of medical services provided by these organizations; and

Whereas, Amazon has not been transparent regarding if or how its medical databases would be integrated with its other massive customer databases; and

Whereas, Amazon has not been transparent regarding how it will ensure the privacy of medical data it accumulates through its healthcare businesses; therefore be it

RESOLVED, That our American Medical Association study privacy protections and the potential for data breaches of healthcare records in large retail settings. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action

should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider.

Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire;
Rhode Island; Vermont

Subject: Independent Medical Evaluation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Independent Medical Evaluation (IME) is typically a non-voluntary, non-
2 consensual legally obligated mandate for persons who are injured or disabled to be evaluated
3 by insurers or employers^{1, 11}; and
4

5 Whereas, The IME evaluation does not involve the typical safeguards of a fiduciary and privacy
6 obligations of the physician to the patient and under current CEJA opinion provides a "limited
7 patient-physician relationship"^{2, 3}; and
8

9 Whereas, The potential for undue influence of personal and corporate interests exist for IMEs.
10 The compensation of the IME examiner inherently raises concerns about potential conflicts of
11 interest and a pro-employer/carrier bias is embedded in the methodology IMEs, and that the
12 practical impact of the IME approach is to reduce the recognition of occupationally related
13 health conditions and to minimize the reported disability associated with such conditions^{4, 5, 6, 12};
14 and
15

16 Whereas, The selection of the IME examiner often involves limited input from the patient; and
17

18 Whereas, There are no consistent national standards safeguarding patient's privacy, or ability of
19 the patient to record, document or bring their own physician or advocate to the IME
20 examination; and
21

22 Whereas, There is a paucity of research documenting a patient centric, objective unbiased
23 outcomes which protect the injured or disabled patient being mandated to undergo an IME^{14, 15};
24 and
25

26 Whereas, There is no established/longitudinal relationship between the IME examiner and the
27 injured or disabled patient; and
28

29 Whereas, There are many different standards to which the examiner must adhere when
30 completing an IME which include but are not limited to federal regulations set forth by the Social
31 Security Administration, local state laws, and the American Medical Association's Guidelines to
32 the Evaluation of Permanent Impairment. There are also guidelines set forth by many American
33 colleges and boards of medical specialties including the American College of Surgeons,
34 American Society of Interventional Pain Physicians, and the American College of Occupational
35 and Environmental Medicine. In addition to many nationally created guidelines, the examiner
36 may also consult the World Health Organizations Disability Assessment Schedules I and II,
37 which provide a simple and unified approach to the disabled patient. No uniform qualifications

1 training or certification have been established for physicians performing IME. Best practices
2 have been suggested by some experts in the field of IME^{6, 16}; and

3 Whereas, There have been a long history of journalistic investigations including the *New York*
4 *Times* documenting the inherent problems of the IME process^{8, 9}; and

5
6 Whereas, Worker and disabled patient advocacy groups have highlighted that injured and
7 disabled patients are discouraged from filing claims for fear of retaliation. The extent of fraud in
8 workers compensation is 1 – 2 %^{10, 17}; and

9
10 Whereas, A substantial body of literature exists questioning the ethical foundation of
11 independent medical examinations (IMEs) in medicolegal cases. IME physicians are prone to
12 biases, in that they are financially motivated to maintain a positive relationship with the
13 insurance carriers that hire them^{12, 13}; and

14
15 Whereas, The following areas should be important considerations: a) qualifications for those
16 performing IME; b) appropriate privacy and informed consent for IME; c) fair and reasonable
17 policies and procedures including due process for including recording, advocacy and access to
18 the examination to their treating physicians for an IME; and d) model state or federal legislation,
19 rules, or regulations to protect the interest of those injured and disabled; therefore be it

20
21 RESOLVED, That our American Medical Association study and report back at the 2024 Annual
22 Meeting on the Independent Medical Evaluation (IME) process and recommend standards and
23 safeguards to protect injured and disabled patients. (Directive to Take Action)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-23)

Introduced by: American Society of Addiction Medicine

Subject: Study on the Criminalization of the Practice of Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The American Medical Association has policy opposing the attempted criminalization
2 of health care decision-making (H-160.946, *The Criminalization of Health Care Decision*
3 *Making*); and

4 Whereas, US District Judge Matthew Kacsmaryk's ruling that the US Food and Drug
5 Administration's (FDA's) approval of Mifepristone was to be suspended was based on junk
6 science and political ideology and threatened the integrity of the FDA itself; and

7
8 Whereas, Florida passed a state statute in 2011, *Florida's Firearm Owner's Privacy Act*, which
9 was a gag law restricting doctors from discussing firearm ownership and firearm safety with
10 patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the
11 four provisions violated the First Amendment rights of physicians; and

12
13 Whereas, At least 30 states have introduced or passed laws that restrict gender-affirming
14 services for minors and/or adults, often resulting in professional or criminal penalties for
15 physicians, parents, and others involved in providing the care; and

16
17 Whereas, At least 13 states have made providing abortions illegal with targeted regulation of
18 abortion providers (TRAP) laws that single out physicians who provide abortion care and are
19 more burdensome than those imposed on physicians who provide comparable types of care.
20 These laws do not increase patient safety and are contrary to evidence-based medicine; and

21
22 Whereas, The Department of Justice (DOJ) has established the Appalachian Regional
23 Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force,
24 specifically to swiftly and effectively prosecute medical professionals¹; and

25
26 Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data
27 analytics to identify and prosecute individual physicians²; and

28
29 Whereas, The DOJ has used non-scientific "red flag" data to, in part, determine physicians to
30 target for prosecution. Among these data are whether patients have traveled more than 30 miles
31 if in an urban area or 120 miles if in a rural area to obtain treatment³; and

32
33 Whereas, Certain specialties are likely to include individual physicians who may find themselves
34 under investigation as a result of successful business practices, a high volume of controlled
35 substance prescribing, or for being one of a few specialists in the area and therefore having
36 patients from a wide catchment area; therefore be it

- 1 RESOLVED, That our American Medical Association study the rapidly changing environment in
- 2 which the practice of medicine has been criminalized, the degree to which such criminalization
- 3 is based or not based upon valid scientific findings, as well as the degree to which this is
- 4 altering the actual practice of medicine due to physician concerns and personal risk
- 5 assessments, reporting back to the HOD no later than the June, 2024 Annual Meeting.
- 6 (Directive to Take Action)

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

Received: 5/8/23

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3. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-23)

Introduced by: Minnesota

Subject: Racism - A Threat to Public Health

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Racism is a public health crisis - a crisis rooted in the institutional, structural, and
2 systemic barriers that continue to affect Black, Indigenous and other communities of color; and
3

4 Whereas, Racism may be intentional or unintentional; operates at many levels within society,
5 and is a barrier to health equity; and
6

7 Whereas, Racism is a social driver of health (like housing, education, and employment) that has
8 a deep impact on the health status of children, adolescents, and adults within marginalized
9 communities; and
10

11 Whereas, Policymakers and our healthcare community need to work to address racism and its
12 barriers, and do what is needed to eliminate the health inequities that disproportionately affect
13 Black, Indigenous and other communities of color; and
14

15 Whereas, Standardizing how the various social drivers of health are recorded in a clinical
16 encounter is needed in order to improve clinical practice, research, and policy; and
17

18 Whereas, Existing codes in the International Classification of Diseases (ICD) system do not
19 encompass some of the most important social drivers of health, including racism; and
20

21 Whereas, Documenting instances where experiencing racism could be a causal factor in a
22 health condition is important; and
23

24 Whereas, Examples of a patient experiencing racism include (1) a patient who presents with
25 chronic stress and high-blood pressure due to exposure to racist abuse or discrimination; and
26 (2) a patient who has experienced frequent racist encounters and is now presenting in clinic with
27 low-grade inflammation; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for the creation of an
30 International Classification of Diseases (ICD) code for patients presenting with conditions
31 related to experiencing racism, a code that will provide physicians with the tools necessary to
32 address racism within the clinical encounter, and capture the data needed to provide more
33 effective patient care. (Directive to Take Action)

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

Received: 5/3/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-23)

Introduced by: Women Physicians Section

Subject: Advocating for Increased Support to Physicians in Family Planning
and Fertility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, One in four female physicians will suffer from infertility,¹ well above the estimated
2 incidence (9%–18%) in the U.S. general population¹; and
3

4 Whereas, Physician fertility and family planning, however, are rarely discussed as part of formal
5 education during medical school, residency, or subsequent practice; and
6

7 Whereas, Among female physicians, infertility, high-risk pregnancies, and miscarriages have
8 been associated with higher rates of burnout—as a cause, a consequence, or both²; and
9

10 Whereas, Evidence suggests female physicians are at higher risk of burnout than their male
11 colleagues due to multiple factors, including work–life integration and gender bias²; and
12

13 Whereas, The lack of physician education on the risks and consequences of infertility
14 exacerbates its potential emotional, physical, and financial impacts. Individuals/couples seeking
15 fertility preservation or treatment for infertility may experience emotional distress, which may
16 manifest as anxiety, guilt, loss of hope, loss of control, bereavement, and stigmatization^{3,4};
17 therefore be it
18

19 RESOLVED, That our American Medical Association advocate for academic and employed
20 physician practices to contract with insurance providers who provide infertility coverage that
21 defrays the steep costs for fertility treatments (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA work with other key stakeholders to encourage full support of
24 physicians desiring to have families to allow for flexible work policies and clinical coverage for
25 those undergoing fertility treatments. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY**Infertility and Fertility Preservation Insurance Coverage H-185.990**

1. Our AMA advocates for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.
3. Our AMA advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility and supports access to fertility preservation services for those affected.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22; Modified: Res. 224, I-22;

Resident and Fellow Access to Fertility Preservation H-310.902

Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

Citation: Res. 302, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Rights of the Developing Baby

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, At the moment of conception a new genetically unique fetus apart from pregnant
2 woman who is carrying it is created; and
3

4 Whereas, That developing fetus has a total dependency of the mother carrying that fetus; and
5

6 Whereas, That mother carrying the fetus, has according to AMA policy passed in I-2022⁽¹⁾ total
7 autonomy over her body; and
8

9 Whereas, At I-2022 affirmed abortion⁽¹⁾ as a human right; and
10

11 Whereas, The point of viability is to be determined by her doctor(s); and
12

13 Whereas, At the point of viability, the doctor(s) has two patients to care for; and
14

15 Whereas, Up until the point of viability, there is no statement of fetal/pre-natal rights in the AMA
16 Code of Ethics (or the AOA Code of Ethics); therefore be it
17

18 RESOLVED, That our American Medical Association's Council of Judicial and Ethical Affairs
19 (CEJA) address the rights of the viable fetus in a report to be delivered no later than the 2024
20 Annual meeting. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. [Report 4 of the Board of Trustees \(I-22\) Preserving Access to Reproductive Health Services](#)

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and

civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993

1. The AMA reaffirms existing policy that:

(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.

2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.

Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Viability of the Newborn

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, At the 2022 Interim meeting a woman's right to abortion was affirmed; and

2
3 Whereas, In that affirmation was a qualifier statement¹ that at the end of pregnancy the only
4 reason for an abortion is the endangerment of the life of the mother or severe fetal abnormalities
5 incompatible with life; and

6
7 Whereas, Current advanced neonatal care has lowered the viability of the newborn to
8 approximately 22 weeks gestation; and

9
10 Whereas, In that qualifier statement¹ there was no mention of care for a potentially viable
11 newborn; therefore be it

12
13 RESOLVED, That our American Medical Association advocate for availability of the highest
14 standard of neonatal care to aborted fetus born alive at a gestational age of viability. (Directive
15 to Take Action)

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

Received: 5/9/23

REFERENCES

1. [Report 4 of the Board of Trustees \(I-22\) Preserving Access to Reproductive Health Services](#)

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and

physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993

1. The AMA reaffirms existing policy that:

(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.

2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.

Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-23)

Introduced by: Illinois

Subject: Serial (Repeated) Sperm Donors

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Some individuals have become multiple sperm donors; and

2
3 Whereas, The female sperm recipient may not be aware that their sperm donor has made
4 multiple donations, and with the continued escalation of DNA and gene testing, the potential for
5 many unknown half cousins or half siblings or relatives is escalating; and

6
7 Whereas, The discovery of the existence of unknown relatives may lead to family and legal
8 concerns unexpectedly; therefore be it

9
10 RESOLVED, That our American Medical Association work with other relevant national medical
11 specialty societies to study the further elaboration of potential risks associated with allowing
12 sperm from a single donor to be used to conceive children by multiple recipients and make
13 recommendations for additional policies to minimize these risks. (Directive to Take Action)

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

Received: 5/5/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Redressing the Harms of Misusing Race in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Pulmonary function tests (PFTs), also known as spirometry, are the standard of care
2 for diagnosing obstructive and restrictive lung diseases such as asthma, emphysema, and
3 interstitial lung disease¹; and
4

5 Whereas, Differences in population averages for PFT values by race and socioeconomic status
6 have long been documented and were used to justify and uphold slavery and structural racism
7 in the United States in the 19th century, to deny workers' compensation claims for Welsh vs.
8 English white miners in the United Kingdom in the early 20th century, and to deny workers'
9 compensation claims for Black asbestos workers in Baltimore in a landmark 1999 case²⁻⁵; and
10

11 Whereas, Differences in population averages for PFT values by race may be explained by
12 racially segregated exposure to environmental toxins, adverse working conditions, poor air
13 quality, and worse access to health care — all of which impact lung health and disease
14 progression⁶⁻¹² — yet widely used PFT reference values based on the National Health and
15 Nutrition Survey (NHANES) have only included a “race adjustment” without accounting for any
16 other relevant factors¹³; and
17

18 Whereas, The *AMA Guides to the Evaluation of Permanent Impairment* has been published for
19 over 50 years and is the main guiding document for workers' compensation evaluations^{14,15}; and
20

21 Whereas, Chapter 5 of the *AMA Guides* 6th edition states that “The [American Thoracic Society]
22 Task Force for Interpretation of Pulmonary Function recommends an adjustment on a
23 population basis for predicted lung function in Blacks,” motivating clinicians to provide
24 differential care by race¹⁵; and
25

26 Whereas, Chapter 5 of the *AMA Guides* 6th edition states that “Reliable population data are not
27 yet available for other ethnic groups, such as Hispanics, Native Americans, and Asians. For
28 these ethnic groups, the values for North American whites may be used,” thereby motivating
29 clinicians to use a reference standard derived only from white populations for a broad array of
30 non-white populations¹⁵; and
31

32 Whereas, The American Thoracic Society, with endorsement from the European Respiratory
33 Society, recently released new recommendations which state that “PFT laboratories should
34 adopt a race-neutral approach to PFT interpretation by reporting and interpreting results using
35 average reference equations” such as the Global Lung Initiative (GLI) aggregated equation,
36 rather than using race-based algorithms^{16,17}; and
37

38 Whereas, Race is a profoundly imprecise proxy for biological characteristics and should be
39 instead characterized as a sociopolitical construct, in accordance with AMA-RFS and AMA
40 policies (350.003R, H-65.953, D-350.981); and

1 Whereas, The economic consequences of using of race to deny workers' compensation to
2 Black individuals is a problematic intersection of the medical field with *racial capitalism* — the
3 “centrality of race in structuring social and labor hierarchies in capitalist economies”¹⁸; and
4

5 Whereas, The misuse of race in clinical algorithms is arguably a civil rights violation¹⁹; and
6

7 Whereas, Other race-based algorithms are actively being or have already been litigated,
8 including a landmark lawsuit recently settled by hundreds of Black former National Football
9 League players who were denied workers' compensation due to a race-normed cognitive testing
10 algorithm, and pending lawsuits related to the now-defunct race-based estimated glomerular
11 filtration rate (eGFR) equations^{20–24}; and
12

13 Whereas, Our American Medical Association recognizes the public health threats of racism (H-
14 65.952), advocates against the use of racial essentialism in medicine and clinical research (D-
15 350.981, H-65.953), and recommends structural and cultural changes to prevent and address
16 racism in healthcare (H-65.951); and
17

18 Whereas, Reparative approaches to address the disparate harms caused to patients by
19 structural racism embedded in health care delivery are already being investigated and
20 implemented at the health system, city, state, and national levels,^{25–37} including federal inquiries
21 from the House Ways & Means Committee and Agency for Healthcare Research & Quality,^{32–34}
22 proposed reforms to Section 1557 of the Affordable Care Act which prohibit the use of
23 discriminatory clinical algorithms,³⁵ a “Blueprint for an AI Bill of Rights” from the Office for
24 Science and Technology Policy,³⁶ and a new “time back” mandate from the Organ Procurement
25 and Transplantation Network to restructure kidney transplant waiting lists to redress harms
26 caused by race-based eGFR equations³⁷; and
27

28 Whereas, Actively ongoing litigation, regulatory agency initiatives, and policymaking to address
29 racism in clinical algorithms will continue to require input from our AMA within the next 6
30 months; therefore be it
31

32 RESOLVED, That our American Medical Association recognize the exacerbation of health and
33 economic inequities due to race-based algorithms as a manifestation of racism within the
34 medical field (New HOD Policy); and be it further
35

36 RESOLVED, That our AMA will revise the *AMA Guides to the Evaluation of Permanent*
37 *Impairment*, in accordance with existing AMA policy on race as a social construct and national
38 standards of care, to modify recommendations that perpetuate racial essentialism or race-based
39 medicine (Directive to Take Action); and be it further
40

41 RESOLVED, That our AMA support and promote racism-conscious, reparative, community-
42 engaged interventions at the health system, organized medical society, local, and federal levels
43 which seek to identify, evaluate, and address the health, economic, and other consequences of
44 structural racism in medicine. (New HOD Policy)
45

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

Received: 5/10/23

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RELEVANT AMA POLICY

Racial Essentialism in Medicine D-350.981

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

Citation: Res. 10, I-20;

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

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

Citation: Res. 11, I-20;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the

causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-23)

Introduced by: New York

Subject: Report Regarding the Criminalization of Providing Medical Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The American Medical Association has policy opposing the attempted criminalization
2 of health care decision-making (H-160.946, *The Criminalization of Health Care Decision*
3 *Making*); and
4

5 Whereas, Physicians and other care providers have been criminally charged for medical errors
6 such as mistaking a dialysis catheter for a feeding tube in NY, mistakenly giving an excessive
7 dose of penicillin to a newborn in Colorado, an error in preparation of a chemotherapy solution
8 for a child in Ohio, mistakenly giving an anesthetic to a teenage patient in Wisconsin¹, and
9 errors in the medical record in Illinois²; and
10

11 Whereas, Florida passed a state statute in 2011, Florida's Firearm Owner's Privacy Act, which
12 was a gag law restricting doctors from discussing firearm ownership and firearm safety with
13 patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the
14 four provisions violated the First Amendment rights of physicians; and
15

16 Whereas, At least other 30 states have introduced or passed laws that have restricts gender-
17 affirming services for minors and/or adults, often resulting in professional or criminal penalties
18 for physicians, parents, and others involved in providing the care; and
19

20 Whereas, At least 13 states have made providing abortions illegal with Targeted regulation of
21 abortion providers (TRAP) laws that single out physicians who provide abortion care and are
22 more burdensome than those imposed on physicians who provide comparable types of care.
23 These laws do not increase patient safety and are contrary to evidence-based medicine; and
24

25 Whereas, The U.S. Department of Justice (DOJ) has established the Appalachian Regional
26 Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force,
27 specifically to swiftly and effectively prosecute medical professionals³; and
28

29 Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data
30 analytics to identify and prosecute individual and corporate actors in healthcare fraud⁴; and
31

32 Whereas, The DOJ has used non-scientific “red flag” data to, in part, determine physicians to
33 target for prosecution. Among these data are whether patients have traveled more than 30 miles
34 if in an urban area or 120 miles if in a rural area to obtain treatment⁵; and
35

36 Whereas, Certain specialties are likely to include individual physicians who find themselves
37 being investigated simply for having a successful business model, or for prescribing a high
38 volume of FDA-approved medication, or for being one of few specialists in the area and
39 therefore having patients from a wide service area; therefore be it

- 1 RESOLVED, That our American Medical Association study the rapidly changing environment in
- 2 which the practice of medicine has been criminalized, the degree to which such criminalization
- 3 is based or not based upon valid scientific findings, as well as the degree to which this is
- 4 altering the actual practice of medicine due to physician concerns and personal risk
- 5 assessments, reporting back to the House of Delegates no later than the 2024 Annual meeting.
- 6 (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Dickinson J. The Criminalization of Human Errors in Healthcare. Published online 27 July 2022. Accessed 4 May 2023 at: https://www.americanbar.org/groups/health_law/publications/aba_health_source/2021-2022/july-2022/criminalization-of-human-errors-in-healthcare/
2. Orient J. Is a Charting Error a Federal Crime? MedCity News-Influencers. 4 May 2013. Accessed 4 May 2023 at: <https://medcitynews.com/2013/05/is-a-charting-error-a-federal-crime/>
3. <https://www.justice.gov/criminal-fraud/arpo-strike-force>
4. <https://www.americanbar.org/news/abanews/aba-news-archives/2021/12/washington-health-law-summit/>
5. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;