

## DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

### AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-23)

#### Report of Reference Committee on Amendments to Constitution and Bylaws

Brandi Ring, MD, MBA, Chair

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Your Reference Committee recommends the following consent calendar for acceptance:

#### **RECOMMENDED FOR ADOPTION**

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 15 - National Cancer Research Patient Identifier
3. BOT Report 21 - Specialty Society Representation in the House of Delegates - Five-Year Review
4. CEJA Report 01- Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
5. CEJA Report 03 - Short-term Medical Service Trips
6. CEJA Report 04 - Responsibilities to Promote Equitable Care
7. CEJA Report 05 - CEJA's Sunset Review of 2013 House Policies
8. Resolution 005 - Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
9. Resolution 010 - Advocating for Increased Support to Physicians in Family Planning and Fertility

#### **RECOMMENDED FOR ADOPTION AS AMENDED**

10. CCB Report 01 - AMA Bylaws and Gender Neutral Language and Miscellaneous Update
11. Resolution 002 - Exclusion of Race and Ethnicity in the First Sentence of Case Reports
12. Resolution 003 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
13. Resolution 004 - Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
14. Resolution 006 - Ensuring Privacy as Large Retail Settings Enter Healthcare
15. Resolution 007 - Independent Medical Evaluation
16. Resolution 009 - Racism - A Threat to Public Health
17. Resolution 014 - Redressing the Harms of Misusing Race in Medicine
18. Resolution 016 - Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization
19. Resolution 017 - Establishing a Formal Definition of "Employed Physician"

**RECOMMEND FOR ADOPTION IN LIEU OF**

- 20. Resolution 018 - Confidentiality of Sexual Orientation and Gender Identity Data;  
Resolution 001 – Opposing Mandated Reporting of LGBTQ+ Status
- 21. Resolution 015 - Report Regarding the Criminalization of Providing Medical Care;  
Resolution 008 - Study on the Criminalization of the Practice of Medicine.

**RECOMMENDED FOR REFERRAL**

- 22. CEJA Report 02 - Ethical Principles for Physicians In Private Equity Owned Practices

**RECOMMENDED FOR NOT ADOPTION**

- 23. Resolution 011 - Rights of the Developing Baby
- 24. Resolution 012 - Viability of the Newborn
- 25. Resolution 013 - Serial (Repeated) Sperm Donors

**Amendments**

If you wish to propose an amendment to an item of business, click here: [SUBMIT  
NEW AMENDMENT](#)

**RECOMMENDED FOR ADOPTION**

- (1) BOARD OF TRUSTEES REPORT 02 - NEW  
SPECIALTY ORGANIZATIONS REPRESENTATION  
IN THE HOUSE OF DELEGATES

**RECOMMENDATION:**

**Recommendations in Board of Trustees  
Report 2 be adopted and the remainder of  
the Report be filed.**

**HOD ACTION: Recommendations in Board  
of Trustees Report 2 adopted and the  
remainder of the Report filed.**

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

Testimony was heard in general support. Your Reference Committee recommends that BOT Report 02 be adopted.

- (2) BOARD OF TRUSTEES REPORT 15 – NATIONAL  
CANCER RESEARCH PATIENT IDENTIFIER

**RECOMMENDATION:**

**Recommendations in Board of Trustees Report  
15 be adopted and the remainder of the Report  
be filed.**

**HOD ACTION: Recommendations in Board of  
Trustees Report 15 adopted and the remainder  
of the Report filed.**

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

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

1 Testimony was heard in support of BOT Report 15. Testimony noted that the National  
2 Cancer Institute is already developing an identification system. Your Reference  
3 Committee recommends that BOT Report 15 be adopted.

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6  
7 (3) BOARD OF TRUSTEES REPORT 21 - SPECIALTY  
8 SOCIETY REPRESENTATION IN THE HOUSE OF  
9 DELEGATES - FIVE-YEAR REVIEW

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11  
12 **RECOMMENDATION:**

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14 **Recommendations in Board of Trustees Report**  
15 **21 be adopted and the remainder of the Report**  
16 **be filed.**

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18 **HOD ACTION: Recommendations in Board of Trustees**  
19 **Report 21 adopted and the remainder of the Report filed.**

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21 The Board of Trustees recommends that the following be adopted, and the remainder of  
22 this report be filed:

23  
24 1. The Aerospace Medical Association, American Academy of Dermatology, American  
25 Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family  
26 Physicians, American Academy of Hospice and Palliative Medicine, American Academy  
27 of Neurology, American Academy of Psychiatry and the Law, American Association for  
28 Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical  
29 Neurophysiology Society, American Rhinologic Society, American Society of Addiction  
30 Medicine, American Society of Echocardiography, American Society of Hematology,  
31 American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society  
32 of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration  
33 Surgery, North American Neuromodulation Society, North American Neuro-  
34 Ophthalmology Society, and Spine Intervention Society retain representation in the AMA  
35 HOD. (Directive to Take Action)

36  
37 2. Having failed to meet the requirements for continued representation in the AMA  
38 House of Delegates as set forth in AMA Bylaw B-8.5, the American College of Medical  
39 Quality, American Society for Reconstructive Microsurgery, American Society of  
40 Neuroimaging, GLMA—Health Professionals Advancing LGBTQ+ Equality be placed on  
41 probation and be given one year to work with AMA membership staff to increase their  
42 AMA membership. (Directive to Take Action)

43  
44 3. Having failed to meet the requirements for continued representation in the AMA  
45 House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year  
46 grace period, the American Society of General Surgeons and United States and  
47 Canadian Academy of Pathology lose representation in the AMA HOD but retain it for  
48 the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the  
49 HOD, through the SSS, when they believe they can comply with all of the current

1 guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2.  
2 (Directive to Take Action)  
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4 Testimony was heard in general support. Your Reference Committee recommends that  
5 BOT Report 21 be adopted.  
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8 (4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
9 REPORT 01 - UTILIZATION REVIEW, MEDICAL  
10 NECESSITY DETERMINATION, PRIOR  
11 AUTHORIZATION DECISIONS  
12

13 **RECOMMENDATION:**  
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15 **Recommendations in Council on Ethical and**  
16 **Judicial Affairs Report 1 be adopted and the**  
17 **remainder of the Report be filed.**  
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19 **HOD ACTION: Recommendations in Council on Ethical and**  
20 **Judicial Affairs Report 1 adopted and the remainder of the**  
21 **Report filed.**  
22

23 Based on the foregoing considerations, the Council on Ethical and Judicial Affairs  
24 recommends that paragraph 2 of D-320.977, "Utilization Review, Medical Necessity  
25 Determination, Prior Authorization Decisions," be rescinded as having been  
26 accomplished and the remainder of this report be filed:  
27

28 1. Our AMA will advocate: (a) for implementation of a federal version of a prior  
29 authorization "gold card" law, which aims to curb onerous prior authorization practices by  
30 many state regulated health insurers and health maintenance organizations; and (b) that  
31 health plans should offer physicians at least one physician-driven, clinically-based  
32 alternative to prior authorization, including a "gold-card" or "preferred provider program."  
33  
34 ~~2. Our AMA will request that the Council on Ethical and Judicial Affairs review current~~  
35 ~~ethical opinions similar to the Texas Medical Association Board of Councilors' opinions~~  
36 ~~regarding medical necessity determination and utilization review.~~  
37

38 (Modify HOD policy)  
39

40 Testimony was heard in unanimous support, noting that prior authorization is a  
41 significant challenge for physicians, and that the recommendations are good for  
42 physicians and patients. Testimony mentioned that COL has a task force working on this  
43 issue and it is a high priority for them. Your Reference Committee recommends that  
44 CEJA Report 01 be adopted.

45  
46 (5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
47 REPORT 03 – SHORT-TERM MEDICAL SERVICE TRIPS  
48  
49

**RECOMMENDATION:**

**Recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 3 referred and the remainder of the Report filed**

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

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

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

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

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

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

Sponsors of short-term medical service trips should:

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

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

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

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

(New HOD/CEJA Policy)

Testimony was mixed. There was testimony suggesting referral, which included that the report is still written from the standpoint of the volunteers and the word "service" implies this work is unidirectional rather than collaborative. Testimony also suggested that there was insufficient discussion of partnering with local organizations and that non-financial harms to overseas partners were not discussed. It was suggested that the word "vulnerability" is not consistent with language recommended by the Center for Health Equity (CHE). However, your Reference Committee wishes to highlight that the issues of collaboration with local partners and the various types of harms service trips might cause are extensively addressed by Recommendations A and B. Further, CEJA was consulted, and points out that the word "vulnerable" does not appear in the recommendations and that the language of the report is consistent with CHE guidelines. CEJA therefore declined to amend the language. Testimony in support offered an amendment to the effect that all the recommendations should also apply to dental service trips, and they

would like to see these included. However, in the judgment of the Reference Committee, such an amendment is not within the purview of the AMA and these guidelines would be more properly developed by the American Dental Association. Your Reference Committee recommends that CEJA Report 03 be adopted.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
REPORT 04 – RESPONSIBILITIES TO PROMOTE  
EQUITABLE CARE

**RECOMMENDATION:**

**Recommendations in Council on Ethical and  
Judicial Affairs Report 4 be adopted and the  
remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Ethical and  
Judicial Affairs Report 4 adopted and the remainder of the  
Report filed**

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)

The majority of testimony was in support of adoption. An amendment was offered; however, CEJA reports cannot be amended without the approval of the Council. The amendment was substantive. Therefore, your Reference Committee recommends adoption of the current report recognizing that CEJA may elect to consider the issues raised in the amendment in a subsequent report. Your Reference Committee recommends that CEJA Report 04 be adopted.

(7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
REPORT 05 – CEJA'S SUNSET REVIEW OF 2013  
HOUSE POLICIES

**RECOMMENDATION:**

**Recommendations in Council on Ethical and Judicial Affairs Report 5 be adopted and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 5 adopted and the remainder of the Report filed**

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

No testimony was heard. Your Reference Committee recommends that CEJA Report 05 be adopted.

(8) RESOLUTION 005 – PROVIDING CULTURALLY AND RELIGIOUSLY SENSITIVE ATTIRE OPTIONS AT HOSPITALS FOR PATIENTS AND EMPLOYEES

**RECOMMENDATION:**

**Resolution 005 be adopted.**

**HOD ACTION: Resolution 005 adopted.**

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)

Mixed testimony was heard. Supportive testimony emphasized the need for cultural and religious sensitivity. Limited testimony in opposition was heard to the effect that scrubs are different from hospital attire and that patient safety in the OR needs to be considered. Your Reference Committee recommends that Resolution 005 be adopted.

(9) RESOLUTION 010 – ADVOCATING FOR INCREASED SUPPORT TO PHYSICIANS IN FAMILY PLANNING AND FERTILITY

**RECOMMENDATION:**

**Resolution 010 be adopted.**

**HOD ACTION: Resolution 010 adopted.**

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

1 RESOLVED, That our AMA work with other key stakeholders to encourage full support  
2 of physicians desiring to have families to allow for flexible work policies and clinical  
3 coverage for those undergoing fertility treatments. (Directive to Take Action)  
4

5 Testimony was heard in unanimous support. Supportive testimony noted that this  
6 resolution is particularly pertinent for some specialties since their residency period is  
7 longer, and thus it may encourage more women to choose those specialties. An  
8 amendment was offered by addition and deletion of a third resolve clause that would  
9 amend current AMA Policy H-185.990 "Infertility and Fertility Preservation Insurance  
10 Coverage." While your Reference Committee generally agrees with the suggested  
11 changes to Policy H-185.990, we do not find the amendment germane to this resolution  
12 and believe that the amendment offered would be more appropriately proffered as its  
13 own resolution in the future. For this reason, your Reference Committee recommends  
14 that Resolution 010 be adopted as written.  
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## 17 RECOMMENDED FOR ADOPTION AS AMENDED

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20 (10) COUNCIL ON CONSTITUTION AND BYLAWS REPORT  
21 01 - AMA BYLAWS AND GENDER NEUTRAL  
22 LANGUAGE AND MISCELLANEOUS UPDATE  
23

### 24 RECOMMENDATION A:

25  
26 Section 3.8 Installation of Officers be amended  
27 by addition as follows:  
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29 3.8 Installation of Officers. The officers of the AMA  
30 shall assume their duties at the close of the meeting at  
31 which they are elected, except as stated herein. The  
32 medical student trustee shall assume office at the  
33 close of the Annual Meeting following the Interim  
34 Meeting at which the medical student trustee was  
35 elected. If elected at an Interim Meeting or Special  
36 Meeting, the public trustee shall assume office at the  
37 close of the Annual Meeting following ~~his or her~~ their  
38 election. If elected at an Annual Meeting, the public  
39 trustee shall assume office at the close of the Annual  
40 Meeting at which they are ~~he or she was~~ elected.  
41

### 42 RECOMMENDATION B:

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44  
45 Recommendations in Council on Constitution and  
46 Bylaws Report 1 be adopted as amended remainder of  
47 the Report be filed.  
48

**HOD ACTION: Recommendations in Council on  
Constitution and Bylaws Report 1 adopted as  
amended and remainder of the Report filed.**

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

**2—House of Delegates**

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**2.8 Alternate Delegates.**

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

**3—Officers**

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**3.4 Elections.**

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**3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if ~~they he or she has~~ have 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 Trustees to be elected.

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**3.5 Terms and Tenure.**

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**3.5.7.1 Limitations.** No candidate shall be eligible for election or re-election as the young physician trustee unless, at the time of election, ~~he or she is~~ they are under 40 years of age or within the first eight years of practice after residency and fellowship

1 training, and ~~is~~ are not a resident/fellow physician. A young physician trustee shall be  
2 eligible to serve on the Board of Trustees for the full term for which elected, even if  
3 during that term the trustee reaches 40 years of age or completes the eighth year of  
4 practice after residency and fellowship training.

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7  
8 **3.8 Installation of Officers.** The officers of the AMA shall assume their duties at the  
9 close of the meeting at which they are elected, except as stated herein. The medical  
10 student trustee shall assume office at the close of the Annual Meeting following the  
11 Interim Meeting at which the medical student trustee was elected. If elected at an Interim  
12 Meeting or Special Meeting, the public trustee shall assume office at the close of the  
13 Annual Meeting following ~~his or her~~ their election. If elected at an Annual Meeting, the  
14 public trustee shall assume office at the close of the Annual Meeting at which ~~he or she~~  
15 ~~was~~ elected.

## 16 17 **6—Councils**

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21 **6.8 Election - Council on Constitution and Bylaws, Council on Medical Education,**  
22 **Council on Medical Service, and Council on Science and Public Health.**

23 \*\*\*  
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25  
26 **6.8.1.2 Other Council Members.** With reference to each such Council, all nominees for  
27 election shall be listed alphabetically on a single ballot. Each elector shall have as many  
28 votes as there are members to be elected, and each vote must be cast for a different  
29 nominee. No ballot shall be counted if it contains fewer votes or more votes than the  
30 number of members to be elected, or if the ballot contains more than one vote for any  
31 nominee. A nominee shall be elected if ~~he or she~~ they have ~~has~~ received a vote on a  
32 majority of the legal ballots cast and ~~is~~ are one of the nominees receiving the largest  
33 number of votes within the number of members to be elected.

## 34 35 **7—Sections**

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39 **7.4 Organized Medical Staff Section.**

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41 **7.4.1 Membership.** Membership in the Section shall be open to all active physician  
42 members of the AMA who are members of a medical staff of a hospital or a  
43 medical staff of a group of practicing physicians organized to provide healthcare.  
44 Active resident and fellow members of the AMA who are ~~selected~~ certified by their  
45 medical staffs as representatives to the Business Meeting also shall be considered  
46 members of the Section.

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**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.

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

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## **7.7 Minority Affairs Section.**

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

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

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## **7.10 Women Physicians Section.**

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

(Modify Bylaws)

Testimony was heard in unanimous support. It was noted that this change follows similar changes in many other major organizations, promotes respect for the dignity of all people, communicates belonging, and challenges marginalization. A minor amendment was offered to make the language consistent throughout. Your Reference Committee recommends that CCB Report 01 be adopted as amended.

(11) RESOLUTION 002 – EXCLUSION OF RACE AND  
ETHNICITY IN THE FIRST SENTENCE OF CASE  
REPORTS

**RECOMMENDATION A:**

That the first resolve of Resolution 002 be  
amended by addition as follows:

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

**RECOMMENDATION B:**

That the second resolve of Resolution 002 be  
amended by addition as follows:

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

**RECOMMENDATION C:**

Resolution 002 be adopted as amended.

**RECOMMENDATION D:**

That the title of Resolution 002 be amended by  
addition as follows:

**RESOLUTION 002 – EXCLUSION OF RACE,  
PREFERRED SPOKEN LANGUAGE, AND  
ETHNICITY IN THE FIRST SENTENCE OF CASE  
REPORTS**

**HOD ACTION:** Resolution 002 adopted as amended with a  
change in title:

**RESOLUTION 002 – EXCLUSION OF RACE,  
PREFERRED SPOKEN LANGUAGE, AND  
ETHNICITY IN THE FIRST SENTENCE OF  
CASE REPORTS**



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

4  
5 RESOLVED, That our AMA encourage the maintenance of race and ethnicity in other  
6 relevant sections of case reports and other medical documentation. (New HOD Policy)

7  
8 Testimony was mixed. An amendment was offered on the basis that “preferred spoken  
9 language” should not be included in the first sentence of case reports since it also can  
10 introduce bias into the treatment of patients. Opposing testimony noted that in order to  
11 have interpreters available, physicians must be able to easily determine which language  
12 is spoken by the patient. Your Reference Committee noted that the second resolve  
13 specifies that these descriptors should still be included in other relevant sections of case  
14 reports, and not eliminated altogether. Online testimony was unanimously in strong  
15 support and stated that removing race from the first sentence of case reports is an  
16 important additional step to eliminating racism in medicine. Your Reference Committee  
17 would like to emphasize that factors such as race, preferred spoken language and other  
18 cultural and social needs are critical for quality patient care and should be included  
19 elsewhere in the patient’s documentation. Your Reference committee recommends that  
20 Resolution 002 be adopted as amended, with a change in title.

21  
22  
23 (12) RESOLUTION 003 – LAYING THE FIRST STEPS  
24 TOWARDS A TRANSITION TO A FINANCIAL AND  
25 CITIZENSHIP NEED BLIND MODEL FOR ORGAN  
26 PROCUREMENT AND TRANSPLANTATION

27  
28 **RECOMMENDATION A:**

29  
30 **That the first resolve of Resolution 003 be**  
31 **amended by addition as follows:**

32  
33 **RESOLVED, That our American Medical Association**  
34 **support initiatives that decrease financial and**  
35 **institutional barriers for organ transplantation to**  
36 **uninsured or insurance-ineligible recipients,**  
37 **regardless of immigration status, who can follow**  
38 **transplant-center specific protocols such that they can**  
39 **receive transplants and obtain required medical care**  
40 **and medications after transplantation, including**  
41 **financial coverage for appropriate living donors,**  
42 **excluding medical tourism as defined in the AMA Code**  
43 **of Ethics 1.2.13 (New HOD Policy); and be it further**  
44

45  
46  
47 **RECOMMENDATION B:**

48  
49 **That the third resolve, subsection (1)(c), of Resolution**  
50 **003 be amended by deletion as follows:**

(c) Non-medical criteria, such as ability to pay, social worth, immigration status, ~~perceived obstacles to treatment or follow-up~~, patient contribution to illness, or past use of resources should not be considered.

**RECOMMENDATION C:**

That the third resolve, subsection (7), of Resolution 003 by amended by addition as follows:

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

**RECOMMENDATION D:**

Resolution 003 be adopted as amended.

**HOD ACTION: Resolution 003 adopted as amended**

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 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

1 criteria. (c) Non-medical criteria, such as ability to pay, social worth, immigration status,  
2 perceived obstacles to treatment or follow-up, patient contribution to illness, or past use  
3 of resources should not be considered.

4  
5 (2) Allocation decisions should respect the individuality of patients and the particulars of  
6 individual cases as much as possible. (a) All candidates for treatment must be fully  
7 considered according to ethically appropriate criteria relating to medical need, as defined  
8 in Guideline 1. (b) When very substantial differences do not exist among potential  
9 recipients of treatment on the basis of these criteria, a "first-come-first-served" approach  
10 or some other equal opportunity mechanism should be employed to make final allocation  
11 decisions. (c) Though there are several ethically acceptable strategies for implementing  
12 these criteria, no single strategy is ethically mandated. Acceptable approaches include a  
13 three-tiered system, a minimal threshold approach, and a weighted formula.

14  
15 (3) Decision making mechanisms should be objective, flexible, and consistent to ensure  
16 that all patients are treated equally. The nature of the physician-patient relationship entails  
17 that physicians of patients competing for a scarce resource must remain advocates for  
18 their patients, and therefore should not make the actual allocation decisions.

19  
20 (4) Patients must be informed by their physicians of allocation criteria and procedures, as  
21 well as their chances of receiving access to scarce resources. This information should be  
22 in addition to all the customary information regarding the risks, benefits, and alternatives  
23 to any medical procedure. Patients denied access to resources have the right to be  
24 informed of the reasoning behind the decision.

25  
26 (5) The allocation procedures of institutions controlling scarce resources should be  
27 disclosed to the public as well as subject to regular peer review from the medical  
28 profession.

29  
30 (6) Physicians should continue to look for innovative ways to increase the availability of  
31 and access to scarce medical resources so that, as much as possible, beneficial  
32 treatments can be provided to all who need them.

33  
34 (7) Physicians should accept their responsibility to promote awareness of the importance  
35 of an increase in the organ donor pool using all available means. (Modify Current HOD  
36 Policy)

37  
38 Testimony unanimously supported Resolution 003. An amendment was offered  
39 emphasizing that all patients must be able to adhere to transplant protocols in order to  
40 be considered for a transplant. The authors of the resolution supported the amendment.  
41 In addition, your Reference Committee offers an amendment to add the word "ethically"  
42 to subsection (7). Your Reference Committee recommends that Resolution 003 be  
43 adopted as amended.

- (13) RESOLUTION 004 – AMENDING POLICY H-525.988,  
“SEX AND GENDER DIFFERENCES IN MEDICAL  
RESEARCH”

**RECOMMENDATION A:**

**That subsection (7) of the third resolve of  
Resolution 004 be referred.**

**RECOMMENDATION B:**

**That the remainder of Resolution 004 be  
adopted as amended.**

**HOD ACTION: Resolution 004 adopted as amended**

RESOLVED, That our American Medical Association facilitate the inclusion of women and sexual and gender minority participants in clinical research studies and reporting of how the sex and gender of these participants influenced study outcomes requires the cooperation of researchers, federal agencies, and journal editors, by amending Policy H-525.988, “Sex and 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)

Testimony was mixed; however, the majority was in support. Online testimony was unanimously in strong support with several delegations citing the lack of inclusion of sexual and gender minorities in clinical research which can affect outcomes and the ability of researchers to properly analyze clinical trial data. Online testimony also noted the need for greater inclusion of sexual and gender minority participants in all aspects of

1 clinical research and the clinical review process to minimize implicit bias and  
2 underreporting of adverse effects.

3  
4 Opposing testimony asked that subsection 7 be referred. Your Reference Committee  
5 believes this is appropriate since it concerns internal FDA procedures, and it is not within  
6 the AMA's purview to encourage or advocate for procedures to be implemented  
7 exclusively within other organizations. Your Reference Committee recommends that  
8 subsection 7 be referred, and that the remainder of Resolution 004 be adopted.

9  
10  
11 (14) RESOLUTION 006 – ENSURING PRIVACY AS LARGE  
12 RETAIL SETTINGS ENTER HEALTHCARE

13  
14 **RECOMMENDATION A:**

15  
16 **That Resolution 006 be amended by addition**  
17 **and deletion as follows:**

18  
19 **RESOLVED, That our American Medical**  
20 **Association study privacy protections, privacy**  
21 **consent practices, and the potential for data**  
22 **breaches, and the use of health data for non-**  
23 **clinical purposes of healthcare records in large**  
24 **retail healthcare settings. (Directive to Take**  
25 **Action)**

26  
27  
28 **RECOMMENDATION B:**

29  
30 **Resolution 006 be adopted as amended.**

31  
32  
33 **RECOMMENDATION C:**

34  
35 **RESOLVED, that the title be amended by**  
36 **addition and deletion as follows:**

37  
38 **ENSURING PRIVACY AS LARGE IN RETAIL**  
39 **HEALTHCARE SETTINGS ENTER HEALTHCARE**

40  
41 **HOD ACTION: Resolution 006 adopted as**  
42 **amended with a change in title:**

43  
44 **ENSURING PRIVACY AS LARGE IN RETAIL**  
45 **HEALTHCARE SETTINGS ENTER HEALTHCARE**

46  
47  
48 **RESOLVED, That our American Medical Association study privacy protections and the**  
49 **potential for data breaches of healthcare records in large retail settings. (Directive to**  
50 **Take Action)**

Testimony was heard in unanimous support, noting that Resolution 006 represents a strong commitment to patient privacy. An amendment was offered regarding use of health data for nonclinical purposes, and your Reference committee agreed with this addition. Your Reference Committee eliminated “large” from the language of the resolution because it should apply to all retail settings, regardless of size. Your Reference Committee recommends that Resolution 006 be adopted as amended, with a title change to reflect these changes.

(15) RESOLUTION 007 – INDEPENDENT MEDICAL EVALUATION

**RECOMMENDATION A:**

**That resolution 007 be amended by addition and deletion as follows:**

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

**RECOMMENDATION B:**

**Resolution 007 be adopted as amended.**

**HOD ACTION: Resolution 007 referred for decision.**

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

Testimony was heard in general support. Testimony in favor of Resolution 007 noted that IMEs are critically important, though IMEs have various meanings and definitions in a variety of contexts. Examples were provided, such as court-ordered or psychiatric evaluations. An amendment was offered that suggested this study should include consultation with a wide variety of experts within the field of IMEs, in particular those familiar with the AMA’s standards. Limited opposition was heard, noting that different fields have different terms, and that Resolution 007 does not capture the complexity of the issue. Your Reference Committee agrees with the rationale and language of the proffered amendment and believes that it addresses the primary concerns raised in opposition. Therefore, your Reference Committee recommends that Resolution 007 be adopted as amended.

(16) RESOLUTION 009 – RACISM - A THREAT TO PUBLIC HEALTH

**RECOMMENDATION A:**

**That resolution 009 be amended by addition and deletion as follows:**

**RESOLVED, That our American Medical Association advocate for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism (including systemic racism and unconscious bias), a code that will provide physicians with a the tools necessary to address document the clinical impact of racism within the clinical encounter, and capture the data needed to help provide more effective patient care.**

**Resolution 009 be adopted as amended.**

**HOD ACTION: Resolution 009 adopted as amended.**

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

Testimony was heard in general support. An amendment was offered to clarify the language. Opposing testimony noted that there already exists an ICD code that addresses racism and that adding a new ICD code could lead to underreporting, which might negatively impact data quality. Testimony in favor responded by claiming that the new ICD code proposed by the resolution is different from existing ICD codes, since it focuses on the patient's unique experience. While creating a new code may not be a perfect means to capture data on racism, it will open up an important conversation about the issue, and that any concerns of underreporting are superseded by the current inability to capture significant patient experiences. Your Reference Committee agrees with the rationale and language of the proffered amendment and recommends that Resolution 009 be adopted as amended.

(17) RESOLUTION 014 – REDRESSING THE HARMS OF  
MISUSING RACE IN MEDICINE

**RECOMMENDATION A:**

**That the third resolve of Resolution 014 be  
amended by addition and deletion as follows;**

**RESOLVED, That our AMA advocate for support  
and promote racism-conscious, reparative,  
community engaged interventions at the health  
system, organized medical society, local, and  
federal levels which seek to identify, evaluate,  
and address the health, economic, and other  
consequences of structural racism in medicine.**

**RECOMMENDATION B:**

**That Resolution 014 be adopted as amended.**

**HOD ACTION: Resolution 014 adopted as amended.**

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

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

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

Testimony was heard in unanimous support of this resolution. In the online testimony, a minor amendment was proffered to the third resolve. Your Reference Committee recommends that Resolution 014 be adopted as amended.



(18) RESOLUTION 016 - SUPPORTING EFFORTS TO  
STRENGTHEN MEDICAL STAFFS THROUGH  
COLLECTIVE BARGAINING AND/OR UNIONIZATION

**RECOMMENDATION A:**

That the first resolve of Resolution 016 be  
amended by addition and deletion as follows:

**RESOLVED**, That our American Medical  
Association reevaluate the various efforts to  
achieve collective actions bargaining and/or  
unionization for physicians nationally (Directive  
to Take Action); and be it further

**RECOMMENDATION B:**

That that the second resolve of Resolution 016 be  
deleted.

~~**RESOLVED**, that our American Medical Association  
develop a specific program of assistance, including  
education in the process of collective actions and  
potentially financial assistance, to be available  
through a process of application, review, and approval  
for organizers of such collective action (Directive to  
Take Action); and be it further~~

**RECOMMENDATION C:**

That Resolution 016 be adopted as amended.

**Recommendation D:**

That the title for Resolution 016 be amended by  
addition and deletion as follows:

**SUPPORTING EFFORTS TO STRENGTHEN MEDICAL  
STAFFS THROUGH COLLECTIVE ACTIONS  
BARGAINING AND/OR UNIONIZATION**

**HOD ACTION:** Resolution 016 adopted as amended with a  
change in title:

**SUPPORTING EFFORTS TO STRENGTHEN  
MEDICAL STAFFS THROUGH COLLECTIVE  
ACTIONS BARGAINING AND/OR UNIONIZATION**

1 RESOLVED, That our American Medical Association reevaluate the various efforts to  
2 achieve collective bargaining and/or unionization for physicians nationally (Directive to  
3 Take Action); and be it further

4  
5 RESOLVED, that our American Medical Association develop a specific program of  
6 assistance, including education in the process of collective actions and potentially  
7 financial assistance, to be available through a process of application, review, and  
8 approval for organizers of such collective action (Directive to Take Action); and be it  
9 further

10  
11 RESOLVED, That our American Medical Association request CEJA to review the  
12 advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to  
13 allow for more flexibility on the part of physicians who have exhausted other non-  
14 disruptive methods for reform (Directive to Take Action).

15  
16 Testimony was heard in general support. Testimony noted that the current landscape  
17 has changed since the last time the AMA reviewed collective action. Current CEJA  
18 wording on collective action was said to be too restrictive, and testimony was raised that  
19 collective action should not be equated with strikes, as there are other forms that  
20 collective action may take. Testimony also noted that burnout and other pressing  
21 physician challenges might be addressed through collective actions. An amendment was  
22 offered to change language from “collective bargaining” to “collective action” within  
23 Resolution 016 as it is wider in scope. Your Reference Committee agrees with the  
24 rationale and language of this proffered amendment. In addition, your Reference  
25 Committee recommends amendment by striking the second resolve, since it is not  
26 possible to develop a program of assistance until the AMA has reevaluated recent efforts  
27 to achieve collective action and CEJA has reviewed existing guidance in Opinion 1.2.10  
28 of the Code of Medical Ethics. Your Reference Committee recommends that Resolution  
29 016 be adopted as amended, with a title change.

30  
31 (19) RESOLUTION 017 - ESTABLISHING A FORMAL  
32 DEFINITION OF “EMPLOYED PHYSICIAN”

33  
34  
35 **RECOMMENDATION A:**

36  
37 **That resolution 017 be amended by deletion as**  
38 **follows:**

39  
40  
41 **RESOLVED, That our American Medical Association**  
42 **adopt the following as its definition of “employed**  
43 **physician”:**

44  
45 **An employed physician is any physician, ~~not in~~**  
46 **training, who derives compensation, financial or**  
47 **otherwise, from a contractual relationship with a**  
48 **practice, hospital, or other funding entity and has no**

1       **direct controlling interest in the entity” (New HOD**  
2       **Policy).**

3  
4       **HOD ACTION: Resolution 017 amended by deletion.**

5  
6       RESOLVED, That our American Medical Association adopt the following as its definition  
7       of “employed physician”:

8       An employed physician is any physician, not in training, who derives compensation,  
9       financial or otherwise, from a contractual relationship with a practice, hospital, or other  
10      funding entity and has no direct controlling interest in the entity” (New HOD Policy).

11  
12      Testimony was heard in overwhelming support of the concept. Further testimony wished  
13      to strike “not in training” from the resolution, since this language would exclude residents  
14      and fellows. In light of the US Supreme Court’s 2011 unanimous decision in *Mayo*  
15      *Foundation v. United States*, which found that medical residents qualify as employees  
16      since they pay payroll taxes, your Reference Committee agrees with the rationale and  
17      language of the proffered amendment and recommends that Resolution 017 be adopted  
18      as amended.  
19

**RECOMMEND FOR ADOPTION IN LIEU OF**

(20) RESOLUTION 001 – OPPOSING MANDATED  
REPORTING OF LGBTQ+ STATUS

RESOLUTION 018 - Confidentiality of Sexual  
Orientation and Gender Identity Data

**RECOMMENDATION A:**

That Resolution 018 be adopted in lieu of  
Resolution 001.

**RESOLVED**, That AMA Policy H-65.959,  
“Opposing Mandated Reporting of People Who  
Question Their Gender Identity” be amended by  
addition and deletion to read as follows:

**Our AMA opposes mandated reporting or  
disclosure of patient information related to  
sexual orientation, of individuals who question  
or express interest in exploring their gender  
identity, gender dysphoria, intersex identity,  
and any information related to gender transition  
for all individuals, including minors.**

**HOD ACTION:** Resolution 018 adopted in lieu of Resolution  
001.

**Resolution 001**

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)

**Resolution 018**

RESOLVED, That AMA Policy H-65.959, “Opposing Mandated Reporting of People Who  
Question Their Gender Identity” be amended by addition and deletion to read as follows:

**Opposing Mandated Reporting of People Who Question Their**

**Gender Identity, H-65.959**

Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors.

Supportive testimony was offered by several delegations regarding the harmful consequences, including physical safety risks, increased stress, mental health degradation and discrimination. Concerns were raised that mandating the reporting of LGBTQ+ status could deter individuals from seeking necessary healthcare. Your Reference Committee believes that Resolution 018 better captures the intent of both resolutions; therefore, your Reference Committee recommends that Resolution 018 be adopted in lieu of Resolution 001.

(21) RESOLUTION 008 – STUDY ON THE  
CRIMINALIZATION OF THE PRACTICE OF  
MEDICINE

RESOLUTION 015 - REPORT REGARDING THE  
CRIMINALIZATION OF PROVIDING MEDICAL  
CARE

**RECOMMENDATION A:**

That Resolution 015 be amended by addition and deletion as follows:

**RESOLVED**, That our American Medical Association study the changing environment in which some medical the practices of medicine has have been criminalized including; and the degree to which such as criminalization is based or not based upon valid scientific findings, as well as the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report reporting back to the HOD no later than the June, 2024 Annual Meeting November 2023 Interim meeting.

**RECOMMENDATION B:**

That Resolution 015 be adopted as amended in lieu of Resolution 008.

**HOD ACTION: Resolution 015 adopted as amended in lieu of Resolution 008.**

**Resolution 008**

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

**Resolution 015**

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

Testimony on both resolutions was supportive. Overwhelming support noted that the criminalization of the practice of medicine has created an environment of increased anxiety and fear that is unacceptable. An amendment was offered to move up the timeframe of the study so that findings could be reported back no later than I-23.

An additional amendment was suggested as follows: “the AMA strongly support any physician charged with a crime arising from their providing care which is in accordance with specialty society guidelines.” Your Reference Committee acknowledges this second amendment and suggests that the feasibility of such support should be included in the study outlined. Online testimony noted that the threat of criminalization has significant implications for both physicians and patients, and an amendment was offered to include how hospitals and health care systems are responding to this rapidly changing environment due to the importance of assessing how hospitals are moving to protect themselves, as there is a risk of physicians and other healthcare professionals becoming scapegoats. Due to the identical nature of Resolution 008 and Resolution 015, your Reference Committee recommends adoption of Resolution 015 in lieu of Resolution 008.

## RECOMMENDED FOR REFERRAL

- (22) COUNCIL ON ETHICAL AND JUDICIAL AFFIARS  
REPORT 02 - ETHICAL PRINCIPLES FOR PHYSICIANS  
IN PRIVATE EQUITY OWNED PRACTICES

### RECOMMENDATION:

**Recommendations in Council on Ethical and  
Judicial Affairs Report 2 be referred back to  
CEJA.**

**HOD ACTION: Recommendations in Council on Ethical and  
Judicial Affairs Report 2 referred back to CEJA.**

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

Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to that~~ before entering into contracts to deliver health care services physicians consider carefully the proposed contract to assure themselves that ~~the~~ its terms and conditions of ~~contracts to deliver health care services before entering into such contracts to ensure~~ that those contracts do not create untenable conflicts of interests do not obviously compromise their ability to fulfill their fiduciary obligations to patients.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards of ~~informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to ~~impede~~ put patients' interests at risk

When ~~contracting~~ partnering with other entities to provide health care services, physicians should:

- (a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

1 (i) Minimizes conflict of interest with respect to proposed reimbursement mechanisms,  
2 financial or performance incentives, restrictions on care or other mechanisms intended  
3 to influence physicians' treatment recommendations or direct what care patients receive,  
4 in keeping with ethics guidance.

5  
6 (ii) Does not compromise physicians' own financial well-being or ability to provide high-  
7 quality care through unrealistic expectations regarding utilization of services or terms  
8 that expose the physician to excessive financial risk.

9  
10 (iii) Allows the physician to appropriately exercise professional judgment.

11  
12 (iv) Includes a mechanism to address grievances and supports advocacy on behalf of  
13 individual patients.

14  
15 (v) Permits disclosure to patients.

16  
17 (vi) Enables physicians to participate in, if not outright control, decisions about practice  
18 staffing.

19  
20 (b) Negotiate modification or removal of any terms that unduly compromise physicians'  
21 ability to uphold ethical standards.

22  
23 When physicians enter into arrangements with partners who may later sell the practice,  
24 physicians should seek explicit commitments that subsequent partners will sustain  
25 fidelity to patients and respect physicians' professional ethical obligations.

26  
27 (Modify HOD policy)

28  
29 Testimony was predominantly in opposition. Testimony noted that the report does not  
30 address the ethical implication of profit expectations, especially if it comes at the cost of  
31 supporting physicians and patients. In general, testimony noted that the  
32 recommendations are not strong enough and lack sufficient detail. In particular, it was  
33 suggested that more clarity is needed on the definition and scope of the term "financial  
34 obligation." Your Reference Committee recommends that CEJA Report 02 be referred  
35 back to CEJA with a request for a report back at I-23.



**RECOMMENDED FOR NOT ADOPTION**

(23) RESOLUTION 011 – RIGHTS OF THE DEVELOPING  
BABY

**RECOMMENDATION:**

**Resolution 011 be not adopted.**

**HOD ACTION: Resolution 011 not adopted.**

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

Overwhelming opposing testimony was heard. Several members stated that the AMA has recently reaffirmed its current policy on reproductive rights, which is in contradiction with Resolution 011. Online testimony in opposition also notes that this issue has been discussed by CEJA in *Code* Opinions 4.1.2 Genetic Testing for Reproductive Decision Making, 7.3.4 Maternal-Fetal Research, 2.2.3 Mandatory Parental Consent to Abortion, and 4.2.7 Abortion. Your Reference Committee recommends that Resolution 011 be not adopted.

(24) RESOLUTION 012 – VIABILITY OF THE NEWBORN

**RECOMMENDATION:**

**Resolution 012 be not adopted.**

**HOD ACTION: Resolution 012 not adopted**

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

Testimony in opposition highlighted that existing CEJA policy already addresses the issues raised by Resolution 012, specifically citing the AMA *Code of Ethics* "Opinion 2.2.14 - Treatment Decisions for Seriously Ill Newborns," in which CEJA offers guidance on children born at the edge of viability. Your Reference Committee recommends that Resolution 012 be not adopted.

1 (25) RESOLUTION 013 – SERIAL (REPEATED) SPERM  
2 DONORS  
3

4 **RECOMMENDATION:**  
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6 **Resolution 013 be not adopted.**  
7

8 **HOD ACTION: Resolution 013 not adopted.**  
9

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

15  
16 Testimony was heard in general opposition. It was noted that ASRM already has policy  
17 on this issue and is conducting research to study the issue further. Your Reference  
18 Committee believes that this resolution is outside of the purview of the AMA and instead  
19 falls within the scope of specialist societies. Your Reference Committee recommends  
20 that Resolution 013 be not adopted.  
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Mister Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Dr. Stephen Richards, Dr. Eugene Sherman, Dr. William Sternfeld, Dr. Jade Anderson, Dr. Mark Casanova, and Dr. Kenath Shamir and all those who testified before the committee.

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American Academy of Family Physicians

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M. Eugene Sherman, MD  
American College of Cardiology

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William Sternfeld, MD  
Ohio Delegation

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Jade A. Anderson, MD  
American College of Radiology

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Mark Casanova, MD  
Texas Delegation

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Kenath Shamir, MD  
Massachusetts Delegation

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Brandi Ring, MD, MBA  
American College of Obstetricians and Gynecologists  
Chair