

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

### **Report(s) of the Board of Trustees**

- 02 New Specialty Organizations Representation in the House of Delegates

### **Report(s) of the Council on Constitution and Bylaws**

- 01 AMA Bylaws—Nomination of Officers and Council Members
- 02 AMA Bylaws—Run-Off and Tie Ballots
- 03 AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)
- 04 AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)

### **Report(s) of the Council on Ethical and Judicial Affairs**

- 01 Short-Term Global Health Clinical Encounters
- 02 Research Handling of De-Identified Patient Data (D-315.969)
- 03 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
- 04 Physicians' Use of Social Media for Product Promotion and Compensation
- 05 CEJA's Sunset Review of 2014 House Policies

### **Resolutions**

- 001 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
- 002 Removal of the Interim Meeting Resolution Committee
- 003 Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
- 004 The Rights of Newborns that Survive Abortion
- 005 AMA Executive Vice President
- 006 Treatment of Family Members
- 007 AMA Supports a Strategy for Eliminating Nuclear Weapons
- 008 Consolidated Health Care Market
- 009 Updating Language Regarding Families and Pregnant Persons
- 012 Ethical Pricing Procedures that Protect Insured Patients
- 013 Ethical Impetus for Research in Pregnant and Lactating Individuals
- 014 The Preservation of the Primary Care Relationship
- 015 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 016 Guiding Principles for the Healthcare of Migrants
- 017 Addressing the Historical Injustices of Anatomical Specimen Use
- 018 Opposing Violence, Terrorism, Discrimination, and Hate Speech
- 019 Supporting the Health of Our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 022 Health and Racial Equity in Medical Education to Combat Workforce Disparities

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-24

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the  
2 applications of the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle  
3 Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society for  
4 Pediatric Dermatology for national medical specialty organization representation in the American  
5 Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by  
6 the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

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

10  
11 Organizations seeking admission were asked to provide appropriate membership information to the  
12 AMA. That information was analyzed to determine AMA membership, as required under 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 2023 Interim  
23 Meeting indicated that the Academy of Consultation-Liaison Psychiatry, American College of  
24 Lifestyle Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society  
25 for Pediatric Dermatology meet the criteria for representation in the HOD.

### 26 27 RECOMMENDATION

28  
29 Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry,  
30 American College of Lifestyle Medicine, American Venous Forum, Association of Academic  
31 Psychiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of  
32 Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX  
Exhibit A

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

**National Medical Specialty Societies**

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

**RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS**

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

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

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
Academy of Consultation-Liaison Psychiatry	378 of 1,471 (26%)
American College of Lifestyle Medicine	974 of 3,937 (25%)
American Venous Forum	115 of 439 (26%)
Association of Academic Physiatrists	162 of 779 (21%)
Society for Pediatric Dermatology	154 of 564 (27%)

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-24

Subject: AMA Bylaws—Nomination of Officers and Council Members

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2023 Interim meeting, the House of Delegates adopted Recommendation 21 of Speakers Report 3, Report of the Election Task Force 2 (Policy G-610.089). Policy G-610.089 directed that Bylaw 6.8.1 be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place. The Council found similar language in Bylaw 3.3. To maintain internal bylaw consistency and to accurately describe the nomination process for Officers and Council members the Council submits amended language for 3.3 and 6.8.1 for House action.

### RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to our AMA Bylaws be adopted, that Policy G-610.989 be rescinded, 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.

### 3 Officers

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**3.3 Nominations.** Nominations for President-Elect, Speaker and Vice Speaker, shall be made ~~from the floor~~ by a member of the House of Delegates at the opening session of the meeting at which elections take place. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made ~~from the floor~~ by a member of the House of Delegates at the opening session of the meeting at which elections take place ~~and may be announced by the Board of Trustees~~.

### 6 Councils

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**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 Nomination and Election.** Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair ~~Nominations shall be made by the chair~~ of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the Opening session of the meeting at which elections take place.

1                                Nominations ~~and~~ may also be made from the floor by a member of the  
2                                House of Delegates at the opening session of the meeting at which elections  
3                                take place.  
4

5    (Modify Bylaws)

Fiscal Note: No Significant Fiscal Impact

**RELEVANT AMA POLICY**

G-610.089, Directives on Nominations from Speakers Report 3. The language in Bylaw 6.8.1, “Nomination and Election” be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 02-A-24

Subject: AMA Bylaws—Run-Off and Tie Ballots  
(Report of ETF 2 - Rec. #13)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 At the 2023 Interim meeting of the American Medical Association (AMA) the House of Delegates  
2 (HOD) considered Recommendation 13 from Speakers Report 3, Report of the Election Task Force  
3 2, that asked that Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for  
4 elections of officers and councils with multiple nominees so that the lowest vote getter on each  
5 ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in  
6 which case both would be dropped. While the Reference Committee recommended adoption of  
7 Recommendation 13, the HOD ultimately referred the recommendation over concerns about  
8 complex onsite bylaw language not being able to be considered at caucuses.

9  
10 The AMA has a long-standing precedent of requiring that all office holders are elected by a  
11 majority of those casting legal ballots. During Council on Constitution and Bylaws (the Council)  
12 discussions of potential bylaw language, it became apparent that there are three very unlikely  
13 scenarios in which a strict elimination of the nominee with the lowest vote tally as proposed in the  
14 Speakers 3-I-23 would enable a nominee who had not received a majority of votes cast to be  
15 elected:

- 16  
17 • For example, if five nominees were running for four vacancies on the Board of Trustees (or  
18 an elected Council), and only three receive a majority of votes, then, of the remaining two,  
19 one would be eliminated, effectively installing a nominee who had not yet received a  
20 majority of votes.
- 21 • Even more unlikely, albeit possible, is a situation whereby those two remaining candidates  
22 tie, and subsequently would then both be eliminated if the Bylaws were strictly interpreted.
- 23 • A similar but even more unlikely event could occur in an election for an officer. For  
24 example, if three nominees (A, B, and C) were running for Speaker in a House of 100  
25 votes, then it is possible that A could receive 34 votes, and B and C could each receive 33.  
26 Again, a strict interpretation of the rule would eliminate both B and C, effectively  
27 installing a Speaker who had not received a majority of votes.
- 28 • The Council noted that a more common occurrence is a multi-vacancy, multi-nominee race  
29 with one more nominee than there are vacancies. For such a race, a more likely outcome is  
30 that two nominees do not attain a majority vote with only one vacancy remaining. and must  
31 run against each other for the remaining vacancy.
- 32 • Lastly, the Council noted that were elections held at the I-23 meeting with a potential of  
33 705 credentialed delegates, theoretically a contested race with three nominees could end in  
34 a three-way tie (with each nominee receiving 235 votes).



Admittedly, these are highly unlikely scenarios, but for completeness, your Council on Constitution and Bylaws felt they should be addressed to avoid controversy should they occur. Minor conditional language has been added in order to prevent such scenarios.

## RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to our 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.

### 3 Officers

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#### 3.4 Elections.

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**3.4.2** Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

##### 3.4.2.1 At-Large Trustees.

**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 have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

~~**3.4.2.1.2 Runoff Ballot.** A runoff election shall be held to fill any vacancy not filled because of a tie vote.~~

~~**3.4.2.1.2**~~ **3.4.2.1.2 Subsequent Ballots.** If all vacancies for Trustees are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the larger number of votes within the number of Trustees to be elected or remaining to be elected, and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice

~~the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.~~

**3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee.** All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

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## **6 Councils**

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### **6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health**

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**6.8.1.1 Separate Election.** The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions result in fewer than two nominees, the nominees with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure

shall be continued until one of the nominees receives a majority of the legal votes cast.

**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 they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of members to be elected.

**6.8.1.3 Run-Off Ballot.** ~~A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.~~

**6.8.1.4 Subsequent Ballots.** If all vacancies are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two remaining nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of council members to be elected or remaining to be elected. and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee. This procedure shall be repeated until all vacancies have been filled.

(Modify Bylaws)

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 03-A-24

Subject: AMA Bylaws—Removal of Officers, Council Members, Committee Members  
and Section Governing Council Members  
(D-610.997)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2023 Interim meeting of the American Medical Association (AMA), the House of Delegates adopted as amended Recommendation 26 from Speakers Report 3: Report of the Election Task Force 2 (D-610.997). Policy [D-610.997](#) asked that our AMA consider developing bylaw language regarding the removal of elected individuals or candidates and the criteria by which such removal would be accomplished and to report back at A-24.

The Council on Constitution and Bylaws (the Council) has developed this report specifically to comprehensively address the removal of officers, council members, and section governing council members. The report does not address candidates as the Council strongly believes this is more appropriately addressed by the Election Committee. Successfully elected candidates would be considered officers or council members and would be covered under the Council's recommendations in this report.

Recommendations are presented for consideration by the House of Delegates.

### BACKGROUND

As part of its fact-finding mission, the Council reviewed applicable bylaws, policies and statutes that address the removal of such parties from office:

#### Bylaws

- AMA Bylaw [3.2.1](#) specifies that AMA membership is a condition for holding office. Nonrenewal of AMA membership would make a candidate or incumbent ineligible to hold office.
- AMA Bylaws for the Resident/Fellow Trustee [[3.5.5.1](#)] and the Medical Student Trustee [[3.5.6.3](#)] have provisions specifying termination of their terms should they no longer qualify as a resident/fellow or medical student (there also is a grace period if this occurs within 90 days of the annual meeting). Similar bylaw provisions exist for residents and medical student members of AMA councils [[6.11](#)].
- Bylaw [1.5](#) states that the Council on Ethical and Judicial Affairs (CEJA) after due notice and hearing, may censure, expel, or place on probation any member of the AMA for an

infraction of the Constitution or these Bylaws, for violation of the Principles of Medical Ethics, or for unethical or illegal conduct.

- Bylaw [3.6.4](#) states that if an officer misses six consecutive regular meetings of the Board of Trustees (Board), this matter shall be reported to the House of Delegates by the Board and the office shall be considered vacant.
- AMA Bylaws provide a mechanism for filling vacancies for all Officers and for the elected and appointed Councils.
- AMA Bylaws do not prohibit the resignation of any Board member or Council member for any reason.
- AMA's Parliamentary Authority, as specified in Bylaw [11.1](#) is the current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC). AIPSC (2<sup>nd</sup> ed.) acknowledges in Section 3.15 the rights of an organization to discipline, suspend and/or expel members, directors and officers in accordance with its bylaws, the parliamentary authority, and within the law.

#### Policies

- The [AMA Principles of Medical Ethics](#) ("Principles") were last revised in June 2001 but initially adopted as the AMA's Code of Conduct when AMA was formed in 1847. The Principles are standards of conduct that define the essentials of honorable behavior for physicians. Principles applicable to this report include:
  - II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
  - III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
  - IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- Policy [H-140.837](#), "Policy on Conduct at AMA Meetings and Events," includes language to the effect that "The CCAM (Committee on Conduct at AMA Meetings and Events) will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following: prohibiting the violator from attending future AMA events or activities; removing the violator from leadership or other roles in AMA activities; prohibiting the violator from assuming a leadership or other role in future AMA activities; notifying the violator's employer and/or sponsoring organization of the actions taken by AMA; referral to the CEJA for further review and action; and referral to law enforcement.

#### Law

- Our AMA is incorporated in the State of Illinois under the General Not For Profit Corporation Act of 1986 (the "Act"). As such, the following provisions apply:
  - Sec. 108.35. Removal of directors.
  - (a) One or more of the directors may be removed, with or without cause. In the case of a corporation having a board of directors which is classified in accordance with

subsection 108.10(e) of this Act, the articles of incorporation or bylaws may provide that such directors may only be removed for cause.

(b) In the case of a corporation with no members or with no members entitled to vote on directors, a director may be removed by the affirmative vote of a majority of the directors then in office present and voting at a meeting of the board of directors at which a quorum is present.

(c) In the case of a corporation with members entitled to vote for directors, no director may be removed, except as follows:

(1) A director may be removed by the affirmative vote of two-thirds of the votes present and voted, either in person or by proxy.

(2) No director shall be removed at a meeting of members entitled to vote unless the written notice of such meeting is delivered to all members entitled to vote on removal of directors. Such notice shall state that a purpose of the meeting is to vote upon the removal of one or more directors named in the notice. Only the named director or directors may be removed at such meeting.

(3) In the case of a corporation having cumulative voting, if less than the entire board is to be removed, no director may be removed, with or without cause, if the votes cast against his or her removal would be sufficient to elect him or her if then cumulatively voted at an election of the entire board of directors.

(4) If a director is elected by a class of voting members entitled to vote, directors or other electors, that director may be removed only by the same class of members entitled to vote, directors or electors which elected the director.

(d) The provisions of subsections (a), (b) and (c) shall not preclude the Circuit Court from removing a director of the corporation from office in a proceeding commenced either by the corporation or by members entitled to vote holding at least 10 percent of the outstanding votes of any class if the court finds (1) the director is engaged in fraudulent or dishonest conduct or has grossly abused his or her position to the detriment of the corporation, and (2) removal is in the best interest of the corporation. If the court removes a director, it may bar the director from reelection for a period prescribed by the court. If such a proceeding is commenced by a member entitled to vote, such member shall make the corporation a party defendant.

(Source: P.A. 96-649, eff. 1-1-10.)

- While the AMA's Office of the General Counsel (OGC) notes that the Act does not directly apply to elected or appointed Council members or appointed committee members, it should be noted that the Illinois statute is broad and vague. Thus, our AMA is fully empowered and has the authority to provide that "all elected and/or appointed individuals" would be required to be bound by the removal language in the statute if so desired. Lastly, OGC advised that whatever is the final determination of the House of Delegates (the "House"), to the extent it conflicts with Illinois law, Illinois law will govern.

## DISCUSSION

As part of its fact-finding, the Council read with interest an article from the American Hospital Association's Trustee Insights, entitled "When a Board Member Crosses the Line: Removing a Trustee Midterm,"<sup>1</sup> whereby organizations are urged to define the desired behaviors of its board members, clarify behaviors that are clearly unacceptable and create a standard process to

<sup>1</sup> Orlikoff, J, When a Board Member Crosses the Line: Removing a Trustee Midterm: Addressing problem behaviors is key to a high performing board. AHA Trustee Insights, September 2023  
[<https://trustees.aha.org/when-board-member-crosses-line-removing-trustee-midterm>]

1 immediately address them if exhibited by any board member. Board members are classified into  
2 four categories: superstars, solid performers, nonperforming/deadweight members, and toxic  
3 members. While nonperforming members are typically managed by an organization through peer  
4 pressure, not being re-elected or appointed, or resignations due to personal or health reasons, the  
5 article supports removal of a toxic member for reasons such as violating the conflict-of-interest  
6 policy, including failure to disclose a conflict; attempting to use information obtained as a board  
7 member in such a way as to derive personal, financial or other benefit; violating the confidentiality  
8 policy; verbally abusing board members, staff or patients/families; any physical assault on board  
9 members, staff or patients/families at any time, in any place; actively working to subvert stated  
10 board policy or decisions; accusation or conviction of felony; speaking against the organization or  
11 the board or the CEO or staff in public; or racist or sexist comments or behavior, failure to attend a  
12 minimum of 50% (or other specified percentage) of board meetings; failing to attend three  
13 consecutive board meetings; and sleeping during board or board committee meetings (two or more  
14 instances).

15  
16 The Council notes that the Standing Rules of the AMA Board of Trustees provide for the removal  
17 of the chair-elect or chair, positions elected internally by Board members. The Council also  
18 emphasizes that existing AMA bylaws, policies and Illinois law cover most but not all, of the other  
19 behaviors defined as unacceptable.

20  
21 In further discussing the issue, the Council noted that only AMA Trustees have a fiduciary  
22 responsibility, and those who do not complete their responsibilities (through negligence or blatant  
23 recklessness) could cause the AMA to incur unnecessary liability.

24  
25 The Council also found that while the Speakers Report did not address the removal of individuals  
26 who serve on appointed councils, the Council believes there should be a comparable process for  
27 removal similar to those who serve on elected councils, with those procedures to be adopted by the  
28 House. Similarly, while Section governing council members have no fiduciary responsibilities, the  
29 bylaws also should incorporate a removal provision, with those Rules to be approved by the AMA  
30 Board of Trustees. Several Section Internal Operating Procedures already provide for the removal  
31 of a governing council member. The Council would work collaboratively with the Council on Long  
32 Range Planning and Development, CEJA, OGC, and the House of Delegates to develop the  
33 procedures to be employed.

34  
35 In perusing other published literature, personal one-on-one intervention is often cited as a less  
36 formal solution to managing problematic board, council or committee members. For example, if an  
37 individual has failed to attend a specified number of meetings in a row, has a specified number of  
38 unexcused absences or has become an impediment to the group's work, the most senior member  
39 often meets informally with the individual in question. Additionally, offering or granting a leave of  
40 absence is another option to make it possible for individuals to take a leave of absence from a  
41 board, council or committee if they have health, work or other reasons why they cannot participate  
42 fully during the current term. AMA Bylaws, Council Rules and Section Internal Operating  
43 Procedures all provide a mechanism for filling vacancies. Lastly, term limits are cited as ways to  
44 minimize less than effective performance, and there are already term limits for AMA Trustees,  
45 Council members and Section governing council members in place.

46  
47 The Council learned that the bylaws or governing documents of several other organizations  
48 incorporated in Illinois, such as the American Dental Association, American Bar Association,  
49 Illinois Association for Behavior Analysis, include provisions that allow for the removal of elected  
50 trustees, council members or committee members, with varying language and detail:

- 1 • **American Dental Association:** ADA Bylaws state that “The House of Delegates may  
2 remove a trustee for cause in accordance with procedures established by the House of  
3 Delegates. The procedures shall provide for notice of the charges alleged and an  
4 opportunity for the accused to be heard in their defense. A two-thirds (2/3) affirmative vote  
5 of the delegates present and voting is required to remove a trustee from office.” The ADA  
6 Governance Manual provides further details that include: The House of Delegates may  
7 remove an elective officer for cause in accordance with procedures established by the  
8 House of Delegates. The procedures shall provide for notice of the charges alleged and an  
9 opportunity for the accused to be heard in his or her defense. A two-thirds (2/3) affirmative  
10 vote of the delegates present and voting is required to remove a trustee from office.  
11
- 12 • Similarly, the ADA Governance Manual includes language to address removal of elected  
13 or appointed Council members: “Removal for Cause. The Board of Trustees may remove a  
14 council member for cause in accordance with procedures established by the Board of  
15 Trustees. Those procedures shall provide for notice of the charges, including allegations of  
16 the conduct purported to constitute each violation and a decision in writing which shall  
17 specify the findings of fact which substantiate any and all of the charges. Prior to issuance  
18 of the decision by the Board of Trustees, no council member shall be excused from  
19 attending any meeting of a council unless there is an opportunity to be heard or compelling  
20 reasons exist which are specified in writing by the Board of Trustees.” Similar language  
21 also exists for the removal of Commission members, “Removal for Cause. Any of the  
22 commissions of this Association shall have the sole authority to remove any of its members  
23 for cause pursuant to its Rules, with notice of such removal being given to the ADA Board  
24 of Trustees.”  
25
- 26 • **Illinois Association for Behavior Analysis -- Removal of Board Member.** An elected  
27 Board Member may be removed from their positions on the Board without cause if such  
28 removal is approved by a majority vote of the membership. An appointed Board Member  
29 may be removed by a majority vote of the Board.  
30
- 31 • **American Psychological Association --** If a standing board or committee believes that  
32 there is reasonable cause to remove a member from said body, a vote may be taken by the  
33 board or committee to petition the Board of Directors to remove said member. If, with the  
34 exception of the individual in question, two-thirds of all members vote to remove said  
35 member, then a petition requesting removal shall inform the Board of Directors of the basis  
36 for, and the evidence supporting, said removal. The Board of Directors shall give said  
37 member the opportunity to fully respond in writing to the petition. The Board of Directors,  
38 by a two-thirds vote of all members, may remove said member if it determines that there is  
39 reasonable cause for removal and that removal is in the best interest of the Association.  
40
- 41 • **American Bar Association –** Bylaw 31.2 allows the President to replace any committee  
42 member who does not participate in the activities of the committee.  
43

44 In conclusion, the Council supports bylaw language that addresses removal of individuals currently  
45 holding a position within the AMA in accordance with procedures approved by the House or the  
46 Board of Trustees. While removal is already possible under Illinois statute, the Council would  
47 support bylaw language for the sake of transparency.



1 RECOMMENDATIONS

2  
3 The Council on Constitution and Bylaws recommends that the following recommendations be  
4 adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed.

- 5  
6 1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption  
7 requires the affirmative vote of two-thirds of the members of the House of Delegates  
8 present and voting:  
9

10 **3. Officers**

11 \*\*\*  
12

13  
14 **3.6 Vacancies.**

15 \*\*\*  
16

17 **3.6.4 Absences.** If an officer misses 6 consecutive regular meetings of the Board,  
18 this matter shall be reported to the House of Delegates by the Board of  
19 Trustees and the office shall be considered vacant. The vacancy shall be filled  
20 as provided in Bylaw 3.6.1 or Bylaw 3.6.3.  
21

22 **3.6.5 Removal for Cause.** Any officer may be removed for cause in accordance  
23 with procedures established by the House of Delegates.  
24

25 **6. Councils**

26 \*\*\*  
27

28  
29 **6.0.1.4 Removal.** A Council member may be removed for cause in accordance with  
30 procedures approved by the House of Delegates.  
31

32 **7. Sections**

33 \*\*\*  
34

35  
36 **7.0.3.4 Removal.** A Governing Council member may be removed for cause in  
37 accordance with procedures approved by the House of Delegates.  
38

39 (Modify Bylaws)  
40

- 41 2) That the Councils on Constitution and Bylaws, Long Range Planning and Development  
42 and the Ethical and Judicial Affairs and the House develop the procedures to remove a  
43 trustee, council member or governing council member for cause. (Directive to Take  
44 Action)  
45  
46 3) That the Election Committee address the need for policy to remove candidates who are  
47 found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles.  
48 (Directive to Take Action)

Fiscal Note: No Significant Fiscal Impact

RELEVANT AMA POLICY

D-610.997, Criteria Regarding Removal of Elected Individuals or Candidates  
Our American Medical Association will consider developing bylaw language regarding removal of elected individuals or candidates and the criteria by which this would be accomplished and to report back at A-24.

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 04-A-24

Subject: AMA Bylaw Amendments Pursuant to AIPSC (2<sup>nd</sup> ed.)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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American Medical Association (AMA) Bylaw 11.1 states that “In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.” The most recent edition of the AIP Standard Code [herein referred to as AIPSC (2<sup>nd</sup> ed.)] became effective as of January 2024.

As noted in informational Speakers Report 3, AIPSC (2<sup>nd</sup> ed.) establishes electronic notice as the default notification and there are several AMA bylaw provisions that specify notification by mail and/or in writing. The Council has prepared bylaw language to ensure that our Bylaws and AIPSC (2<sup>nd</sup> ed.) are consistent.

### RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following recommendations 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:

- 1) That our AMA Bylaws be amended by insertion and deletion as follows:

**2.12.2 Special Meetings of the House of Delegates.** Special Meetings of the House of Delegates shall be called by the Speaker on ~~written or electronic~~ request by ~~of~~ one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall notify ~~mail a notice to the last known address of~~ each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

\*\*\*

**2.12.3.1 Invitation from Constituent Association.** A constituent association desiring a meeting within its borders shall submit an invitation ~~in writing~~, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of

1 the Board of Trustees at any time, but not later than 60 days prior to the dates selected for  
2 that meeting.

3 \*\*\*\*

4  
5 **5.2.4 Notice of Meeting.** Notice is given if delivered in person, by telephone, ~~mail~~, or any  
6 means of electronic communication approved by the Board of Trustees. Notice shall be  
7 deemed to be received upon delivery to the Trustee's contact information then appearing  
8 on the records of the AMA.

9  
10 **5.2.4.1 Waiver of Notice.** ~~Notice of any meeting need not be given if waived in~~  
11 ~~writing before, during or after such meeting.~~ Attendance at any meeting shall constitute  
12 a waiver of notice of such meeting, except where such attendance is for the express  
13 purpose of objecting to the transacting of any business because of a question as to the  
14 legality of the calling or convening of the meeting.

15  
16 \*\*\*\*

17  
18 **12.3 Articles of Incorporation.** The Articles of Incorporation of the AMA may be  
19 amended at any regular or special meeting of the House of Delegates by the approval of  
20 two-thirds of the voting members of the House of Delegates registered at the meeting,  
21 provided that the Board of Trustees shall have approved the amendment and provided it to  
22 ~~submitted it in writing to~~ each member of the House of Delegates at least 5 days, but not  
23 more than 60 days, prior to the meeting of the House of Delegates at which the amendment  
24 is to be considered.

25  
26 (Modify Bylaws)

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

CEJA Report 1-A-24

Subject: Short-Term Global Health Clinical Encounters

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Short-term global health clinical encounters deploy physicians and physicians in training from wealthy communities to provide care in under-resourced settings 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, these trips have a problematic history and run the risk of causing harm to the patients and communities they intend to benefit [1]. To minimize harm and ensure significant benefits, participants, 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 under-resourced settings. However, by making explicit the conditions under which short-term global health clinical encounters are ethically sound and articulating the fundamental ethical responsibilities of those who participate in and sponsor such trips, ethics guidance can promote immediate benefit to individuals and sustainable benefit for host 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 global health clinical encounters and offers guidance for physicians, physicians in training, and sponsors to help them address the ethical challenges of providing clinical care in under-resourced settings. The encounters and perspective of host communities may reveal concerns not specifically addressed in this report. However, the guidance provided emphasizes the critical importance of ethical intent and collaboration with host communities, thus encouraging ongoing conversations between visiting medical teams and host communities regarding cultural, ethical, and practical concerns.

## THE APPEAL OF SHORT-TERM GLOBAL HEALTH CLINICAL ENCOUNTERS

Just how many clinicians and trainees volunteer to provide medical care in under-resourced settings 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 participant 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

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

1 Association of American Medical Colleges found that among students who graduated in 2017–  
2 2018 between 25% and 31% reported having had some “global health experience” during medical  
3 school [4].  
4

5 A variety of reasons motivate physicians and trainees to participate in these projects. For many,  
6 compelling motivations include the opportunities to help address health inequities, improve their  
7 diagnostic and technical skills as clinicians, or explore global health as a topic of study [2]. Global  
8 health clinical encounters may also be pursued to serve the goals of building one’s resume,  
9 improving one’s professional prospects, and gaining the esteem of peers and family [2].  
10

#### 11 A NOTE ON TERMINOLOGY

12  
13 The literature is replete with different terms for the activity of traveling to an under-resourced  
14 community to provide medical care on a volunteer basis, including “short-term medical  
15 volunteerism” [5], “short-term medical missions” [6], “short-term medical service trips” [7,8],  
16 “short-term experience in global health” [9,10], “global health field experience” [11], “global  
17 health experience,” and “international health experience”[2].  
18

19 The Council on Ethical and Judicial Affairs prefers “short-term global health clinical encounters.”  
20 This identifier is generally accepted and encompasses both clinical and educational activities. It  
21 also recognizes that such encounters are not exercises in pure altruism, but a mutually beneficial  
22 collaboration between those planning and participating in these encounters and host communities.  
23 The term also highlights the fact that these activities are limited in duration, which has implications  
24 for the ethical obligations of participants and their impact on host communities.  
25

#### 26 MEDICAL CARE IN UNDER-RESOURCED SETTINGS

27  
28 Traditionally, short-term global health clinical encounters focused on providing clinical care as a  
29 charitable activity, not infrequently under the auspices of faith-based institutions, whose primary  
30 goal was to address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of  
31 improving the health and well-being of host communities [9]. Many also offer training  
32 opportunities for medical students, residents, and local healthcare professionals [9,10,11]. Ideally,  
33 short-term global health clinical encounters are part of larger, long-term efforts to build capacity in  
34 the health care systems being visited, and ultimately to reduce global health disparities [9,10].  
35

36 The medical needs of host communities differ from those of participants’ home countries—  
37 participants may encounter patients with medical conditions they have not seen before, or who  
38 present at more advanced stages of disease, or are complicated by “conditions, such as severe  
39 malnutrition, for which medical volunteers may have limited experience” [7]. At the same time,  
40 available treatment options will often include medications, procedures or tools with which  
41 participants are not familiar. As such, the practice of medicine in under-resourced communities  
42 should be considered a unique area of expertise, requiring specific background and training in order  
43 to be effective [12].  
44

45 By definition, short-term global health clinical encounters typically take place in contexts of scarce  
46 resources. The communities where these encounters take place often have limited access to health  
47 care, often lack access to food, and often lack both economic and political power [7]. As a result,  
48 they may feel unable to refuse assistance that is offered [10]. Moreover, short-term global health  
49 clinical encounters take place under the long shadow of colonialism, including medicine’s role in  
50 that [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and  
51 dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should

recognize that it is a privilege to practice and train in under-resourced communities, and that justice requires reciprocity and equal respect among local and visiting 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 global health clinical encounters.

## ETHICAL RESPONSIBILITIES IN SHORT-TERM GLOBAL HEALTH CLINICAL ENCOUNTERS

Emerging guidelines identify the following ethical duties for participants of short-term global health clinical encounters 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 global health clinical encounters 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, and acceptable to, the host community [9]. Those involved with short-term global health clinical encounters 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? [7]? Ideally, a short-term global health experience 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 global health clinical encounters, so too is identifying and minimizing the burdens such trips place on the host communities.

Beyond lodging, food, and other direct costs of short-term global health clinical encounters, which are usually reimbursed to host communities [9], such trips can place other, less visible burdens on host communities. Physicians, trainees, and others who organize or participate in short-term global health clinical encounters 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, 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].

Sharing information beforehand as to how visiting health care professionals are expected to interact with the host community, the team's objectives, and the skill, and training they bring, can reveal potential benefits and harms, thus allowing them to be discussed and addressed before the team embarks on the experience. 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, host communities and institutions, including local trainees (when the trip includes providing training for the host community) [11].

## Respecting Persons & Cultures

Physicians and trainees who participate in short-term global health clinical encounters 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 professional ethics 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 to provide medical care in under-resourced settings should be aware that the interactions they will have there 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 understandings 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. Participants 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 under-resourced communities, 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 perhaps superior) skills and knowledge simply by virtue of their association with Western medicine [19].

Individuals do not bear these responsibilities alone. Organizations and institutions that sponsor short-term global health clinical encounters have a responsibility to make appropriate orientation and training available to participants 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 participants during the experience.

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]. Participants will likely be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [16]. Participants 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].



## 1 PREPARATION FOR THE EXPERIENCE

2  
3 Fulfilling these fundamental ethical responsibilities requires meeting other obligations with respect  
4 to organizing and carrying out short-term global health clinical encounters. Specifically, sponsoring  
5 organizations and institutions have an obligation to ensure thoughtful, diligent preparation to  
6 promote a trip's overall goals, including appropriately preparing participants for the experience.  
7 Physicians and trainees, for their part, have an obligation to thoughtfully choose those programs  
8 with which they affiliate themselves [1,2,9,11].  
9

### 10 Prepare Diligently

11  
12 Guidelines from the American College of Physicians recognize that “predeparture preparation is  
13 itself an ethical obligation” even though this is far from a universal practice at present [9,cf. 2,12].  
14 Collaborative planning can identify what material resources and clinical skills participants should  
15 be expected to bring to the effort. For example, what activities participants should be assigned, or  
16 whether local mentors are needed or desirable and how such relationships will be coordinated [11].  
17

18 Supervision of trainees also needs to be explicitly arranged and followed up once they arrive in the  
19 host community. Studies show that 20% of participants reported inadequate supervision during  
20 their trips, and it is common for medical schools to allow “students to arrange encounters abroad  
21 without faculty supervision and support” [18,12]. Allowing students to practice in under-resourced  
22 settings without proper supervision is a clear violation of their fiduciary duty.  
23

24 Thoughtful preparation includes determining what nonclinical skills and experience participants  
25 should have to contribute to the overall success of the experience. For example, the goal of  
26 supporting capacity building in the local community calls for participants who have “training  
27 and/or familiarity with principles of international development, social determinants of health,  
28 ...public health systems” and in some cases, health care administration [10,12]. Without this  
29 background, interventions may result in “resource wasting and potentially poorer patient care”  
30 [12].  
31

32 Adequately preparing physicians and trainees for short-term global health clinical encounters  
33 encompasses planning with respect to issues of personal safety, vaccinations, unique personal  
34 health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally  
35 important, to contribute effectively and minimize “culture shock” and distress, participants need a  
36 basic understanding of the context in which they will be working [1,2,7]. Without expecting them  
37 to become experts in local culture, participants should have access to resources that will orient  
38 them to the language(s), traditions, norms, and expectations of the host community, not simply to  
39 the resources and clinical challenges they are likely to face. Participants should have sufficient  
40 knowledge to conduct themselves appropriately, whether that is in how they dress, how they  
41 address or interact with different members of the community, or how they carry out their clinical  
42 responsibilities [7]. They also need to know to whom they can turn for guidance. If at all possible,  
43 this should be someone from outside the host community, since community members may be  
44 reluctant to “push back” against the judgments and actions of participants [19].  
45

46 Preparation should also include explicit attention to the possibility that participants will encounter  
47 ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the  
48 real possibility that physicians and trainees will encounter situations in which they “are unable to  
49 act in ways that are consistent with ethics and their professional values” or “feel complicit in a  
50 moral wrong” [9]. In particular, participants will be required to assess “how to balance risks and  
51 benefits [for patients who have been economically marginalized and who are experiencing illnesses

with which they have little clinical experience] ... how to distribute limited medical resources, and when non-intervention is the appropriate choice” [15]. In addition, participants may find that local beliefs are inconsistent with their own ethical commitments. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such encounters. 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, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect withdrawing will have on patients, the medical team, and the larger goals of the experience, in keeping with ethics guidance on the exercise of conscience. In addition, participants should keep in mind that some care is not always better than no care, and should ensure that they are able to provide safe, respectful, patient-centered care in the context of the specific host community at all times. This context requires cultural respect and awareness on the part of participants, as well as ongoing attention to the fact that certain treatment decisions may become burdensome to the local medical community once the volunteers leave.

#### Choose Thoughtfully

Individual physicians and trainees who participate in short-term global health clinical encounters are not typically 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 and professional responsibilities discussed above [9,10,11]. Participants 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]. Participants 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 participant and then sending participants 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 global health clinical encounters have a responsibility to monitor and evaluate the effectiveness of their programs, and to disseminate their findings in a transparent manner [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 global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced 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 encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.

Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, 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 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 global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term global health clinical encounters 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 project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters 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 visiting 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 participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.
- (c) Provide resources that help them become broadly knowledgeable about the communities in which they will work and 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 visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants 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.
- (d) Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer

1 guidance regarding the evaluation process of the experience, in an effort to enhance and  
2 improve the outcomes of future encounters.

3  
4 Sponsors of short-term global health clinical encounters should:(e) Ensure that resources  
5 needed to meet the defined goals of the trip will be in place, particularly resources that cannot  
6 be assured locally. This includes arranging for local mentors, translation services, and  
7 participants' personal health needs. It should not be assumed that host communities can absorb  
8 additional costs, even on a temporary basis.

9  
10 (f) Proactively define appropriate roles and permissible range of practice for members of the  
11 visiting medical team, so that they can provide safe, high-quality care in the host  
12 community. Team members should practice only within the limits of their training and  
13 skills in keeping with professional standards they would deem acceptable in their ordinary  
14 clinical practice, even if the host community's standards are more flexible or less  
15 rigorously enforced.

16  
17 (g) Ensure appropriate supervision of trainees, consistent with their training in their home  
18 communities, and make certain that they are only permitted to practice independently in  
19 ways commensurate with their level of experience in under-resourced settings.

20  
21 (h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized  
22 standards for the conduct of health services research and quality improvement activities in  
23 the sponsor's country.

24  
25 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

## REFERENCES

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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)  
Research Handling of De-Identified Patient Data  
(D-315.969)

EXECUTIVE SUMMARY

In adopting policy D-315.969, “Research Handling of De-Identified Patient Data,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and the risks of re-identification.

This report articulates a series of recommendations on how best to respond to the increasing collection, sale, and use of de-identified patient data and the associated risks. The report outlines how health data exist within digital information ecosystems, how such complex ecosystems pose challenges to data privacy, how de-identified data functions as a public good for clinical research, and how de-identified data derived within the context of health care institutions lead to certain ethical standards for and protections of that data.

Because CEJA recognizes both the promise of de-identified datasets for advancing health and the concerns surrounding the use of de-identified patient data including the risks of re-identification that extend from the level of individual physicians collecting clinical data to hospitals and other health care institutions as repositories and stewards of data, this report proposes a new Code of Medical Ethics opinion be adopted in conjunction with amendments to four existing opinions to provide ethics guidance in this rapidly evolving digital health ecosystem.

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

CEJA Report 2-A-24

Subject: Research Handling of De-Identified Patient Data  
(D-315.969)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Policy D-315.969, “Research Handling of De-Identified Patient Data,” adopted by the American  
2 Medical Association (AMA) House of Delegates in November 2021, asked the Council on Ethical  
3 and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and  
4 the risks of re-identification.

5  
6 In its informational report on de-identified data [[CEJA 6-A-23](#)], CEJA examined a range of  
7 challenges that health care professionals and institutions are now confronted with as technological  
8 innovations rapidly evolve both within and outside of health care, blurring the boundary  
9 distinctions between these spheres. CEJA’s exploration suggested that in this dynamic environment,  
10 foundational ethical concepts of privacy and consent likely need to be revisited to better reflect that  
11 personal health information today exists in digital environments where responsibilities are  
12 distributed among multiple stakeholders.

13  
14 This report expands on the previous work to articulate a series of recommendations on how best to  
15 respond to the increasing collection, sale, and use of de-identified patient data and the associated  
16 risks. The report outlines how health data exist within digital information ecosystems, how such  
17 ecosystems pose challenges to data privacy, what the *Code* says about data privacy and informed  
18 consent, how de-identified data functions as a public good for clinical research, how privacy  
19 scholars are reconceptualizing privacy as contextual integrity, and how de-identified data derived  
20 within the context of health care institutions lead to certain ethical standards for and protections of  
21 that data.

22  
23 Because CEJA recognizes both the promise of de-identified datasets for advancing health and the  
24 concerns surrounding the use of de-identified patient data including the risks of re-identification  
25 that extend from the level of individual physicians collecting clinical data to hospitals and other  
26 health care institutions as repositories and stewards of data, this report proposes a new ethics  
27 opinion in conjunction with amendments to four existing opinions to provide ethics guidance in  
28 this rapidly evolving digital health ecosystem.

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

## HEALTH DATA & DIGITAL ECOSYSTEMS

De-identified patient data are a subset of health data that exists within larger digital health information ecosystems [1]. Such ecosystems are highly dynamic and distributed, with health information often being combined from multiple datasets and distributed among multiple stakeholders [1]. Traditionally, health data has referred to patient health information produced from patient–physician interactions and stored by health care organizations [2]. This type of data is typically recorded as identifiable patient data and entered into the patient’s electronic medical record (EMR); from there, it can be de-identified and bundled together with other patient data to form an aggregated dataset. In the age of Big Data, however, where large datasets can reveal complex patterns and trends, diverse sets of information are increasingly brought together. Health data now extends to all health-relevant data, including data collected anywhere from individuals both passively and actively that can reveal information about health and health care use [2].

Within digital health ecosystems, health-related data can be generated by health care systems (e.g., EMRs, prescriptions, laboratory data, radiology), the consumer health and wellness industry (e.g., wearable fitness tracking devices, wearable medical devices such as insulin pumps, home DNA tests), digital exhaust from daily digital activities (e.g., social media posts, internet search histories, location and proximity data), as well as non-health sources of data (e.g., non-medical records of race, gender, education level, residential zip code, credit history) [2]. The ethical challenges raised by such widely distributed data ecosystems, with their vast array of data types and multiple stakeholders, require a holistic approach to the moral issues caused by digital innovation. Digital ethics has arisen as a theoretical framework to analyze these recent challenges and examine such ethical concerns from multiple levels of abstraction. The digital ethics framework takes into account the general environment in which ethical concerns arise and examines ethical dilemmas as they relate to information and data, algorithms, practices and infrastructure, and their impact on the digital world [3].

## CHALLENGES TO DATA PRIVACY

In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints on the sharing of “protected health information,” including individually identifiable health information contained in the EMR, by “covered entities,” including physicians, hospitals, pharmacies, and third-party payers. HIPAA’s scope is narrow and does not cover other health-relevant data, such as data generated voluntarily by patients themselves, for example, through the use of commercial health-related apps or devices, or identifiable data individuals provide to municipal authorities, utilities, retailers, or on social media. Furthermore, information that began in the medical record can take on a new, independent life when linked with personal information widely available through datasets generated outside of health care. As McGraw and Mandl explain, “since HIPAA’s coverage is about ‘who’ holds the data, but not what type of data, much of the health-relevant data collected today are collected by entities outside of HIPAA’s coverage bubble and thus resides outside of HIPAA’s protections” [2]. HIPAA is thus limited in its ability to protect patient data within digital health information ecosystems.

Complicating the matter is the fact that once patient health data has been de-identified, it is no longer protected by HIPAA, and can be freely bought, sold, and combined with other datasets. Hospitals now frequently sell de-identified datasets to researchers and industry. Recent developments in AI and its use within health care have similarly created new difficulties.

Patients, and patient privacy advocates, are often concerned about who has access to their data. As data ecosystems have grown larger and more distributed, this has become increasingly more



difficult to ascertain. In the age of Big Data, the global sale of data has become a multibillion-dollar industry, with individuals' data viewed by industry as "new oil" [1]. The global health care data monetization market alone was valued at just over \$0.4 billion in 2022 and is expected to grow to \$1.3 billion by 2030 [4]. Industry often purchases hospital datasets to improve marketing and sales, predict consumer behaviors, and to resell to other entities. Within health care and research settings, the massive datasets collected from clinical data—used initially in the care and treatment of individual patients—have created the potential for secondary use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations [5].

The dynamic and distributed nature of today's digital health information ecosystems challenges the prevailing procedural model for protecting patient privacy: informed consent and de-identification. In a world where the secondary use of patient data within large datasets can easily enter into a global marketplace, the intended use is almost impossible to discern. Patients cannot be honestly and accurately informed about the specific terms of interactions between their collected data and the data collector and any potential risks that may emerge [1,6]. Therefore, patients are unable to truly give informed consent. Furthermore, whether de-identifying datasets truly prevents individual data subjects from being re-identified has been increasingly called into question. Removing the 18 identifiers specified in HIPAA does not ensure that the data subject cannot be re-identified by triangulation with identifying information from other readily available datasets [7]. Machine learning and AI technologies have advanced to the point that virtually all de-identified datasets risk re-identification, such that "even when individuals are not 'identifiable', they may still be 'reachable'" [6].

A final avenue to consider with respect to private health information and patient privacy is the risk of health care data breaches. Raghupathi et al note, "[h]ealthcare is a lucrative target for hackers. As a result, the healthcare industry is suffering from massive data breaches" [8]. The number of health care data breaches continues to increase every year, exposing the private health information of millions of Americans. Despite being heavily targeted by cybercriminals, health care providing institutions are widely considered by cybersecurity experts to lack sufficient security safeguards [8]. Raghupathi et al note, "healthcare entities gathering and storing individual health data have a fiduciary and regulatory duty to protect such data and, therefore, need to be proactive in understanding the nature and dimensions of health data breaches" [8].

## CLINICAL DATA AND PRIVACY

Within the *Code*, [Opinion 3.1.1](#), "Privacy in Health Care," distinguishes four aspects of privacy:

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

The *Code* does not explicitly examine whether personal medical or health information are ethically distinct from other kinds of personal information (e.g., financial records) or in what way. Current guidance treats the importance of protecting privacy in all its forms as self-evident, holding that respecting privacy in all its aspects is of fundamental importance, "an expression of respect for autonomy and a prerequisite for trust" [Opinion 3.1.1]. However, [Opinion 3.3.3](#), "Breach of Security in Electronic Medical Records," directly acknowledges that data security breaches create potential "physical, emotional, and dignity harms" to patients. Similarly, [Opinion 7.3.7](#), "Safeguards in the Use of DNA Databanks," states that breaches of confidential patient information

“may result in discrimination or stigmatization and may carry implications for important personal choices.”

Violations of privacy can result in both harm—tangible negative consequences, such as discrimination in insurance or employment or identity theft—and in wrongs that occur from the fact of personal information being known without the subject’s awareness, even if the subject suffers no tangible harm [7]. Price and Cohen note that privacy issues can arise not only when data are known, but when data mining enables others to “generate knowledge about individuals through the process of inference rather than direct observation or access” [7].

## CLINICAL DATA AND INFORMED CONSENT

With respect to [Opinion 2.1.1](#), “Informed Consent,” in the *Code*, successful communication is seen as essential to fostering trust that is fundamental to the patient–physician relationship and to supporting shared decision making. Opinion 2.1.1 states: “[t]he process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention.” In seeking a patient’s informed consent, physicians are directed to include information about “the burdens, risks, and expected benefits of all options, including forgoing treatment” [Opinion 2.1.1]. It should be noted, however, that no direct mention of patient data is discussed in the opinion, other than that documentation of consent should be recorded in the patient’s medical record.

## CLINICAL DATA, DATASETS, AND THE PUBLIC GOOD

Because aggregated clinical data has the potential for secondary use that can benefit all of society, it has been argued that such data should be treated as a form of public good [5]. When clinical data are de-identified and aggregated, the potential use for societal benefits through research and development is an emergent, secondary side effect of electronic health records that goes beyond individual benefit. Larson et al argue that not only does the public possess an interest in safeguarding and promoting clinical data for societal benefits, but all those who participate in health care systems have an ethical responsibility to treat such data as a form of public good [5]. They propose:

all individuals and entities with access to clinical data inherently take on the same fiduciary obligations as those of medical professionals, including for-profit entities. For example, those who are granted access to the data must accept responsibility for safeguarding protected health information [5].

This entails that any entity that purchases private health information, whether or not it has been de-identified, has an ethical obligation to adhere to the ethical standards of health care where such data were produced. Hospitals thus have an ethical responsibility to ensure that their contracts of sale for datasets insist that all entities that gain access to the data adhere to the ethical standards and values of the health care industry.

This is particularly important when we recall that the wide distribution of digital health information ecosystems increasingly includes non-health-related parties from industry that may have market interests that conflict with the ethical obligations that follow health data. Within this framework, the fiduciary duty to protect patient privacy as well as to society to improve future health care follows the data and thus applies to all entities that use that data, such that all entities granted access to the data become data stewards, including for-profit parties [5]. This also includes patients, such that they bear a responsibility to allow their data to be used for the future improvement of

1 health care for society, especially when we recognize that current health care has already benefited  
2 from past data collection [5].  
3

4 While the re-identification of aggregated patient data should generally be prohibited, there are rare  
5 exceptions. There may be occasions when researchers wish to re-identify a dataset, such as  
6 sometimes occurs in the study of rare diseases that rely on international registries; in such  
7 situations, all individuals must be re-contacted, and their consent obtained in order to re-identify  
8 their data since this would represent a significant change to the initial research protocols and  
9 respective risks [9]. Re-identification of datasets for research is uncommon, however, because  
10 obtaining re-consent can be difficult and can lead to flawed research if data is lost because patients  
11 do not re-consent. The other situation in which it may be permissible, or even obligatory, to re-  
12 identify aggregated patient data is when doing so would be in the interest of the health of individual  
13 patients, such as might occur in the study of a rare genetic disorder. Even within these exceptions,  
14 the risks associated with re-identification remain and re-identified data should thus never be  
15 published. Re-identification of de-identified patient data for any other purposes, by anyone inside  
16 or outside of health care, must be avoided.  
17

#### 18 AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

19

20 Within today's digital health information ecosystems, physicians and hospitals face several  
21 challenges to protecting patient privacy. Barocas and Nissenbaum contend that "even if [prevailing  
22 forms of consent and anonymization] were achievable, they would be ineffective against the novel  
23 threats to privacy posed by big data" [6]. A more effective option, Nissenbaum has argued, would  
24 understand privacy protection as a function of "contextual integrity," i.e., that in a given social  
25 domain, information flows conform to the context-specific informational norms of that domain.  
26 Whether a transmission of information is appropriate depends on "the type of information in  
27 question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints  
28 under which this transmission takes place" [10]. The view of privacy as contextual integrity—that  
29 our conception of privacy is contextual and governed by various norms of information flow—  
30 recognizes that there exist different norms regarding privacy within different spheres of any  
31 distributed digital ecosystem [7,11]. The challenge within health care, as we have seen, is how to  
32 balance these various norms when they conflict and how to ensure that health care's ethical  
33 standards and values are maintained throughout the distributed use of de-identified private health  
34 information.  
35

#### 36 THE CONTEXTUAL INTEGRITY OF DE-IDENTIFIED HEALTH DATA

37

38 In handling patient data, individual physicians strive to balance supporting and respecting patient  
39 privacy while also upholding ethical obligations to the betterment of public health. Through their  
40 own actions, as well as through their membership organizations and through their health care  
41 organizations, physicians should: (1) ensure that data entered into electronic records are accurate  
42 and reliable to the best of their ability; (2) be transparent with patients regarding the limited extent  
43 to which their data can be safely protected, how their data may be used, and why the use of such  
44 data is crucial for improving health care outcomes within society; and (3) ensure that proper  
45 oversight and protections of data are in place, including contractual provisions that any data sold or  
46 shared with outside entities stay in alignment with the ethical standards of the medical profession,  
47 and that meaningful sanctions or penalties are in place and enforced against any actors that violate  
48 those ethical standards. It is critical to recognize, as is outlined in the *Code*, that the patient-  
49 physician relationship is built on trust, and that this trust relies heavily on transparency.

1 It is important for both patient care and research that clinical data entered into the EMR be as  
2 accurate and complete as possible. Some data capture practices, such as copying-and-pasting daily  
3 progress notes from previous encounters, which may contribute to efficiency, can lead to  
4 documentation errors [12]. One avenue for improving EMR accuracy is that, under HIPAA,  
5 patients have the right to access their data and request any perceived errors be amended. While  
6 there is no one solution to improving accuracy of EMR data, further study into how to improve  
7 EMR accuracy is important. One challenge to both EMR accuracy and completeness is the limited  
8 interoperability of different EMR systems. Matching digital health records for the same patient  
9 across and within health care facilities can be a challenge, further contributing to the potential for  
10 EMR errors. Standardization of recording data elements, such as capturing patient address and last  
11 name in a consistent format, may improve matching of patient records and thus improve the  
12 accuracy of the EMR [13].

14 Another challenge to EMR data quality is the risk of bias, primarily due to implicit bias in EMR  
15 design and underrepresentation of patients from historically marginalized groups, low  
16 socioeconomic status, and rural areas [14,15]. Critically important for research involving data  
17 collected from EMRs, available EMR data only reflects those with access to health care in the first  
18 place. While certain study designs and tools have been developed to reduce these biases in  
19 research, physicians and health care institutions should be looking into ways to reduce bias within  
20 EMRs, such as features to optimize effective EMR use and to consistently capture patient data,  
21 especially data on race/ethnicity and social determinants of health that are often inconsistently and  
22 inaccurately captured in EMR systems [14,15,16].

24 Patients have a right to know how and why their data are being used. While physicians should be  
25 able to answer questions regarding patient data as they relate to HIPAA protections, it is the  
26 responsibility of health care institutions to provide more detailed information regarding  
27 expectations of data privacy, how patient data may be used, and why such use is important to  
28 improve the future of health care. Health care systems may consider fulfilling this ethical  
29 obligation by creating a patient notification of data use built into the patient registration process  
30 (using language similar to the National Institutes of Health's (NIH) Introduction-Description  
31 component, meant to provide prospective research participants with an introduction to and  
32 description of the planned storage and sharing of data and biospecimens [17]).

34 As stewards of health data, health care institutions have an ethical responsibility to protect data  
35 privacy. This fiduciary duty to patient data should be seen as following the data even after they are  
36 de-identified and leave the institution where they were initially captured [5,8]. While hospitals and  
37 health care organizations increasingly come under cyberattack, they consistently lag behind other  
38 industries in cybersecurity [18]. With regards to protecting the data they maintain, health care  
39 institutions have a responsibility to make more significant investments in cybersecurity.

41 In order to ensure that the ethical standards of health care are maintained even after data leaves  
42 health care institutions, McGraw and Mandl propose that companies collecting or using health-  
43 relevant data could be required to establish independent data ethics review boards [2]. They write  
44 that such boards could be similar to Institutional Review Boards but should focus more on privacy  
45 than on participant risk, evaluating proposed data projects for legal and ethical implications as well  
46 as their potential to improve health and/or the health care system [2]. In practice, ethics review  
47 boards involved with industry face challenges to both independence and efficacy. Independence  
48 can be compromised by influences such as conflicts of interest, while efficacy can be compromised  
49 by the absence of authority, procedures, and systems to enact recommendations made by these  
50 review bodies. To be effective, data ethics review boards must be independent and free of conflicts  
51 of interest from the company or organization whose data research proposal(s) they are evaluating

1 and have systems in place for both transparency and implementation of feedback for remediations  
2 of privacy and other quality and ethics concerns. Though not a comprehensive solution,  
3 independent data ethics review boards could be an effective safeguard against industry conflicts of  
4 interest and should be considered as a required part of contracts of sale of health data, with  
5 contracts stipulating that any future resale of the data also undergo review by a data ethics review  
6 board.

7  
8 An additional safeguard is the implementation of regular data audits to assess the quality and use of  
9 shared data [19]. These regulatory measures could be implemented as requirements outlined in  
10 Data Use Agreements or Data Sharing Agreements (DSAs). Such agreements have the potential to  
11 establish data governance policies and practices within health care institutions regarding “what data  
12 can be shared, with whom, under what conditions, and for what purposes.” In developing DSAs,  
13 hospital administrators should engage all relevant stakeholders, require a neutral entity be  
14 designated as an independent custodian of shared data, limit the types and/or characteristics of  
15 shared data to certain purposes, and apply additional safeguards to protect the data [20].

16  
17 The need for more transparent disclosure to patients regarding their data use as well as the  
18 importance of building the values of medical ethics into the contracts of sale of aggregate datasets  
19 created by hospitals highlights the fact that the ethical responsibilities to respond to the risks of de-  
20 identified data should not be borne by physicians alone. Respecting patient privacy and their  
21 informed consent are responsibilities that physician member organizations and health care  
22 institutions must take on because the risks to these rights that patients face within digital health  
23 ecosystems radiate far beyond the patient–physician relationship to areas where individual  
24 physicians have little influence.

## 25 26 RECOMMENDATIONS

27  
28 In light of the challenges considered with regard to constructing a framework for holding  
29 stakeholders accountable within digital health information ecosystems, the Council on Ethical and  
30 Judicial Affairs recommends:

### 31 32 1. That the following be adopted:

33  
34 Within health care systems, identifiable private health information, initially derived from and  
35 used in the care and treatment of individual patients, has led to the creation of massive de-  
36 identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a  
37 means for quality improvement and innovation that can be used for the benefit of future  
38 patients and patient populations. While de-identification of data is meant to protect the privacy  
39 of patients, there remains a risk of re-identification, so while patient anonymity can be  
40 safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive  
41 to balance supporting and respecting patient privacy while also upholding ethical obligations to  
42 the betterment of public health.

43  
44 When clinical data are de-identified and aggregated, their potential use for societal benefits  
45 through research and development is an emergent, secondary use of electronic health records  
46 that goes beyond individual benefit. Such data, due to their potential to benefit public health,  
47 should thus be treated as a form of public good, and the ethical standards and values of health  
48 care should follow the data and be upheld and maintained even if the data are sold to entities  
49 outside of health care. The medical profession’s responsibility to protect patient privacy as well  
50 as to society to improve future health care should be recognized as inherently tied to these

1 datasets, such that all entities granted access to the data become data stewards with a duty to  
2 uphold the ethical values of health care in which the data were produced.

3  
4 As individuals or members of health care institutions, physicians should:

- 5  
6 (a) Follow existing and emerging regulatory safety measures to protect patient privacy;  
7  
8 (b) Practice good data intake, including collecting patient data equitably to reduce bias in  
9 datasets;  
10  
11 (c) Answer any patient questions about data use in an honest and transparent manner to the  
12 best of their ability in accordance with current federal and state legal standards.  
13

14 Health care entities, in interacting with patients, should adopt policies and practices that  
15 provide patients with transparent information regarding:

- 16  
17 (d) The high value that health care institutions place on protecting patient data;  
18  
19 (e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of  
20 re-identification does exist;  
21  
22 (f) How patient data may be used;  
23  
24 (g) The importance of de-identified aggregated data for improving the care of future patients.  
25

26 Health care entities managing de-identified datasets, as health data stewards, should:

- 27  
28 (h) Ensure appropriate data collection methods and practices that meet industry standards to  
29 support the creation of high-quality datasets;  
30  
31 (i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing  
32 Agreements for the use of de-identified datasets that may be shared, sold, or resold;  
33  
34 (j) Develop models for the ethical use of de-identified datasets when such provisions do not  
35 exist, such as establishing and contractually requiring independent data ethics review  
36 boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and  
37 potential resale of clinically-derived datasets;  
38  
39 (k) Take appropriate cyber security measures to seek to ensure the highest level of protection is  
40 provided to patients and patient data;  
41  
42 (l) Develop proactive post-compromise planning strategies for use in the event of a data  
43 breach to minimize additional harm to patients;  
44  
45 (m) Advocate that health- and non-health entities using any health data adopt the strongest  
46 protections and seek to uphold the ethical values of the medical profession.  
47

48 There is an inherent tension between the potential benefits and burdens of de-identified  
49 datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-  
50 identification of data may be permissible, or even obligatory, in rare circumstances when done  
51 in the interest of the health of individual patients. Re-identification of aggregated patient data

for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and

2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2, "Confidentiality and Electronic Medical Records" be amended by addition as follows:

- a. Opinion 2.1.1, Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

- (a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
- (b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
  - (i) the diagnosis (when known);
  - (ii) the nature and purpose of recommended interventions;
  - (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
- (c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)

- b. Opinion 3.1.1, Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

- (a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
- (b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
- (c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.
- (d) Be transparent with any inquiry about existing privacy safeguards for patient data but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)

c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:

- (a) Only provide data that has been de-identified.
- (b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:

- (c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.



(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.

(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to establish that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)

d. Opinion 3.3.2, Confidentiality and Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;

(ii) capacity to routinely monitor/audit access to records;

(iii) measures to ensure data security and integrity; and

(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and

3. That the remainder of this report be filed.

Fiscal Note: Less than \$500

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REPORT 3 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)  
Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices  
(D-140.951)

EXECUTIVE SUMMARY

In adopting policy D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to “study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership”.

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. While not inherently unethical, private equity firms’ incursion into health care warrants caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, “Contracts to Deliver Health Care Services” to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

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

CEJA Report 3-A-24

Subject: Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices  
(D-140.951)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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In response to [Policy D-140.951](#), “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices,” which 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”, your Council on Ethical and Judicial Affairs (CEJA) presented Report 02-A-23, which offered recommendations on amending *Code Opinion 11.2.3*, “Contracts to Deliver Health Care Services.” Testimony at the 2023 Annual Meeting of the House of Delegates was predominantly in opposition to the report; concerns were raised regarding the profit motives of private equity and the ethical implications of such businesses’ involvement in health care. Overall, testimony expressed a desire that a stronger stance be taken against private equity’s involvement in health care, and the report was referred back to CEJA.

### BACKGROUND

The past several decades have seen an increase in the corporatization, financialization, and commercialization of health care [1,2]. Since 2018, more physicians now work as employees of hospitals or health care systems rather than serving in private practice [3,4]. Our AMA reports that this trend is continuing: “[e]mployed physicians were 50.2% of all patient care physicians in 2020, up from 47.4% in 2018 and 41.8% in 2012. In contrast, self-employed physicians were 44% of all patient care physicians in 2020, down from 45.9% in 2018 and 53.2% in 2012” [4]. A major factor in these trends has been the incursion of private equity into health care. It is estimated that private equity capital investment between 2000 and 2018 grew from \$5 billion to \$100 billion [1]. Between 2016 and 2017 alone, the global value of private equity deals in health care increased 17%, with health care deals comprising 18% of all private equity deals in 2017 [5].

Private equity firms use capital from institutional investors to purchase private practices, typically utilizing a leveraged buy-out model that finances the majority of the purchase through loans for which the physician practice serves as security, with the goal of selling the investment within 3 to 7 years and yielding a return of 20-30% [1,5,6]. However, private equity investment broadly encompasses many types of investors and strategies, including venture capital firms that primarily invest in early-stage companies for a minority ownership, growth equity firms that tend to partner

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

1 with promising later-stage ventures, and traditional private equity firms that borrow money through  
2 a leveraged buyout to take a controlling stake of mature companies [7].

3  
4 When ownership shifts from physicians to private equity firms, the firms typically seek to invest  
5 resources to expand market share, increase revenue, and decrease costs to make the practice more  
6 profitable before selling it to a large health care system, insurance company, another private equity  
7 firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand  
8 market share, private equity typically employs a “platform and add-on” or “roll-up” approach in  
9 which smaller add-ons are acquired after the initial purchase of a large, established practice,  
10 allowing private equity firms to gain market power in a specific health care segment or sub-  
11 segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions  
12 within health care, significantly contributing to the consolidation of the health care industry that  
13 has dramatically increased over the past decade [9].

14  
15 Proponents of private equity investments in health care claim that private equity provides access to  
16 capital infusions, which may facilitate practice innovation and aid in the adoption of new  
17 technological infrastructure [6,8]. Proponents also advocate that private equity can bring “valuable  
18 managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase  
19 healthcare access by synergistically aligning profit incentives with high quality care provision”  
20 [10].

21  
22 Critics argue that private equity’s focus on generating large, short-term profits likely establishes an  
23 emphasis on profitability over patient care, which creates dual loyalties for physicians working as  
24 employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits  
25 likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-  
26 emphasis on profitable services, limits access to care for certain patient populations (such as  
27 uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or  
28 Medicare patients), and fundamentally limits physician control over the practice and clinical  
29 decision making [5,8,10].

30  
31 Despite strong opinions regarding private equity’s incursion into medicine, empirical research on  
32 the effects of private equity investments in health care, and the impacts on patient outcomes, is  
33 currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because  
34 “[p]rivate equity firms aren’t required to publicly disclose acquisitions or sales, and the widespread  
35 use of nondisclosure agreements further contributes to opacity about practice ownership and the  
36 nature of transactions” [6]. Private equity firms are emerging to be major employers of physicians.  
37 Currently, it is estimated that 8% of all private hospitals in the U.S. and 22% of all proprietary for-  
38 profit hospitals are owned by private equity firms [11].

#### 39 40 ETHICAL ISSUE

41  
42 Private equity firms’ commitment to ensuring high returns on their investments creates a potential  
43 ethical dilemma when investing in health care. Whether or not it may be ethically permissible for  
44 physicians to sell their practices to private equity firms or for physicians to work as employees for  
45 such acquisitions largely depends on how private equity investments impact patient care and  
46 outcomes. This report will examine how private equity investments in health care may be ethical,  
47 the circumstance and factors to be weighed, as well as how physicians may ethically navigate  
48 private equity buyouts and employment.

## RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

A major concern of physicians regarding private equity investments in health care is the potential loss of autonomy, which physicians worry could translate into hospital policies designed for profitability and that limit physicians' decision-making and their ability to care for patients [9]. Loss of autonomy is also associated with increased physician burnout [12]. There are also valid concerns that private equity ownership leads to increased patient volumes and more expensive and potentially unnecessary procedures [9].

## REVIEW OF RELEVANT LITERATURE

### *Empirical Evidence in Medical Literature*

More research is needed on the effects of private equity investments in the health care sector, as little empirical evidence exists on how private equity impacts utilization, spending, or patient outcomes. There is widespread concern among physicians that private equity-controlled practices result in worse patient outcomes.

The best evidence that private equity acquisition of hospitals harms patients is a recent difference-in-differences study by Kannan et al of hospital-acquired adverse events and hospitalization outcomes associated with private equity acquisitions of U.S. hospitals [13]. Data from 100% Medicare Part A claims at 51 private equity-acquired hospitals were compared with data from 259 matched control hospitals (not acquired by private equity) for hospital stays between 2009 and 2019. While there was no differential change in mortality 30 days after hospital discharge, the researchers did find that after private equity acquisition, Medicare beneficiaries admitted to private equity-owned hospitals experienced a 25.4% increase in hospital-acquired conditions compared with those treated at control hospitals. This increase in hospital-acquired conditions, which are established measures of inpatient quality and are considered preventable, was largely driven by a 27.3% increase in falls and a 37.7% increase in central line-associated bloodstream infections at private equity-acquired hospitals [13]. The increase in central-line associated infections after private equity acquisition occurred even as these hospitals saw a 16% reduction in percutaneous central line placement. Kannan et al hypothesize that such increases in hospital-acquired infections could result from decreases in staffing, as such adverse events have been shown to be correlated with staffing ratios among nurses and that private equity often will reduce staffing and change the clinician labor mix at acquired hospitals as a cost-cutting strategy [13].

In another difference-in-differences study of 578 private equity-acquired practices in dermatology, gastroenterology, and ophthalmology matched with a control group of 2,874 non-private equity-acquired practices, Singh et al found a mean increase of 20.2% in charges per claim and a consistent increase in patient utilization over the first eight quarters after acquisition, with the increase in patient utilization primarily driven by a 37.9% increase in visits by new patients [14]. Overall, the researchers found that "private equity acquisition was associated with increases in health care spending and several measures of utilization, and some evidence of greater intensity of care" [14]. They also found increased coding intensity, and posit that this finding could be due to either changes in coding and billing practices that have more efficient charge capture or, conversely, could reflect upcoding to increase revenues [14]. The motivating factors behind this impact on coding deserves further study.

In a systematic review of 55 studies evaluating trends in private equity ownership in health care and the impacts on outcomes, costs, and quality, Borsa et al found that private equity ownership was associated with an increase in cost to patients or payers, primarily from increased charges and

rates for services as well as inconclusive, mixed results on how private equity impacts quality of care [10]. The majority of the studies (n=47) evaluated private equity ownership of health care operations in the US, but represented a range of settings, the most common of which were nursing homes (n=17), hospitals (n=9), dermatology (n=9), and ophthalmology (n=7). Only eight studies included health outcomes, with two finding beneficial impacts, three findings harmful impacts, and three finding neutral impacts; the three that found harmful impacts were all studies of nursing homes [10]. These results suggest that private equity may impact segments of the health care industry differently.

In their analysis of 281 private equity acquisitions involving 610 unique target hospitals, Gao et al found that over an eight-year window, acquisitions were associated with increased profitability, no change in the rate of closures, no statistically significant changes in mortality or readmission rates, and that the percentage of Medicare and Medicaid patients stayed relatively the same [15]. Over the eight year window, private equity-acquired hospitals increased their operating income by 7.4%. Compared to their matched control groups, private equity-acquired hospitals were equally or more likely to survive, contrary to the prevailing narrative. Private equity-acquired hospitals initially experienced a 14% decrease in the number of core workers (medical workers that include physicians, nurses, and pharmacists) over the first four years but over the next four years this difference dissipates to only 2% and is not statistically significant. In contrast, the decline in administrative workers is significant and persistent, with a reduction of 18% within the first four years of acquisition and a 22% reduction by the end of eight years. This reduction in administrative workers was most profound at nonprofit hospitals. Core workers' wages were not found to change, while administrative workers' wages declined by 7%. No changes to patient mortality rates or readmission were found, except for a 0.9% increase in readmission following pneumonia. In looking at rates of stroke, complications and infections during hospitalization as measure of patient outcomes, no statistically significant differences were found between private equity-acquired hospitals, the control group, or non-private equity acquired hospitals. Private equity-acquired hospitals appear to treat a higher number of resource-intensive patients and decrease their outpatient ratio. Gao et al conclude: "[o]verall, our evidence suggests that PE acquirers improve the operating efficiency of target hospitals without a compromise in healthcare quality" [15].

### *Normative and Substantive Views in Ethics and Medical Literature*

The debate over private equity's incursion into health care often regards private equity acquisitions through a lens of exceptionalism—either negatively or positively. However, although private equity owned hospitals are different in their ownership structure and oversight compared to other traditional health care investors, private equity-acquired hospitals may not be substantively different from other for profit and non-profit hospitals in terms of their stated goals of both solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and that there are likely good and bad actors as is the case in many sectors [6]. They add: "physicians should be aware that private equity's growth is emblematic of broader disruptions in the physician-practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise" [6].

The corporatization of medicine is not without ethical and professional risks, of course. In their ethical analysis of orthopaedic surgery practices owned by non-physicians, Moses et al note that the incentives and goals of surgeons might be misaligned with those of the investors, pitting patient care against profits; profit maximization might also lead to wasteful overtreatment as well as a loss of physician autonomy within the practice as well as patient autonomy if physicians are encouraged to be more paternalistic to achieve financial goals [3].



1 Veatch notes that business ethics and medical ethics are not inherently at odds but admits that  
 2 differences do exist [16]. Veatch highlights that physicians are uncomfortable with any removal of  
 3 professional control that may accompany the increasing commercialization of the physician's role.  
 4 Veatch points out that paradoxically, despite being open to the profit motive in the practice of  
 5 medicine, the practice as a whole has shown strong resistance to the commercialization of medical  
 6 practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental  
 7 right or a commodity like any other, adding that the notion of health care as a right jeopardizes any  
 8 profit motive in health care including traditional private practitioner fee-for-service models [16].  
 9

10 Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human  
 11 good that society has an obligation to provide in some measure to all citizens [17]. Pellegrino  
 12 argues that health care is substantively different from traditional market goods—it is not fungible,  
 13 cannot be proprietary because medical knowledge is possible only due to collective achievements,  
 14 is realized in part through the patient's own body, and requires an intensely personal relationship—  
 15 and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine  
 16 turns any interaction between the patient and physician into a commercial transaction subject to the  
 17 laws and ethics of business rather than to medical and professional ethics. "In this view,"  
 18 Pellegrino writes, "inequities are unfortunate but not unjust [...]. In this view of health care,  
 19 physicians and patients become commodities too" [17]. Rather than claiming that health care is a  
 20 fundamental right, Pellegrino takes a position of distributive justice to argue that health care is a  
 21 collective good. Because a good society is one in which each citizen is enabled to flourish, and  
 22 good health is a condition of human flourishing, society has a moral responsibility to provide  
 23 health care to all citizens. In this light, health care is both an individual and a social good.  
 24 Pellegrino also refers to this view as one of "beneficent justice" and explains, "[t]reating health  
 25 care as a common good implies a notion of solidarity of humanity, i.e., the linkage of humans to  
 26 each other as social beings" [17]. Pellegrino concludes:  
 27

28       Understanding health care to be a commodity takes one down one arm of a bifurcating  
 29       pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking  
 30       health care as a human good takes us down a divergent pathway to the resolution of  
 31       injustice through a moral ordering of societal and individual priorities [17].  
 32

33 Whether health care is understood as a commodity or a human good is of course not always so  
 34 clear in policy and in practice. What is evident, however, is that as health care has become  
 35 increasingly commodified, the ethical risks to patients and physicians are being realized as  
 36 physicians find themselves increasingly working as employees and worrying about the impact that  
 37 commercial enterprises—such as private equity investments—may be having on patients.  
 38

39 Private equity represents the latest and most extreme form of health care commercialization that  
 40 has escalated over the past few decades. This is the very reason why private equity firms became  
 41 interested in health care in the first place—they recognized that health care as a market was already  
 42 ripe for investment and future profitability. Private equity firms use the same investment models in  
 43 health care that they do in other industries—invest in fragmented markets, acquire the most  
 44 promising targets as a platform, expand through add-on acquisitions, and exit the market once a  
 45 significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each  
 46 individual acquisition is typically too small to require review by anti-trust regulators at the Federal  
 47 Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers  
 48 and acquisitions in the health care sector [9].

1 Fuse Brown and Hall explain, “[private equity] functions as a divining rod for finding market  
2 failures—where PE has penetrated, there is likely a profit motive ripe for exploitation” [1]. They  
3 continue that private equity investments pose three primary risks:

4  
5 First, PE investment spurs health care consolidation, which increases prices and potentially  
6 reduces quality and access. Second, the pressure from PE investors to increase revenue can  
7 lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding,  
8 harming patients through unnecessary care, excessive bills, and increasing overall health  
9 spending. Third, physicians acquired by PE companies may be subject to onerous  
10 employment terms and lose autonomy over clinical decisions [1].  
11

12 While the profit motive of private equity firms may drive them to take part in less than scrupulous  
13 practices, such as private equity’s exploitation of out-of-network surprise billing, there is also  
14 potential for private equity to play a more positive role in transforming health care practices [1,18].  
15 Powers et al write:

16  
17 Ultimately, private equity—a financing mechanism—is not inherently good or bad.  
18 Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-  
19 service construct, this is intrinsically problematic. But value-based payment models can  
20 serve as an important guardrail, helping to ensure that financial return to private equity  
21 investors are appropriately aligned with system goals of access, quality, equity, and  
22 affordability [18].  
23

24 Private equity firms could help accelerate changes in health care payment and delivery towards  
25 value-based models. With such models, where financial performance is tied to quality and value,  
26 private equity may be incentivized to invest in changes that support better health and lower costs  
27 [18].  
28

29 While more research is needed on the impacts of private equity investments in health care, private  
30 equity firms’ involvement in health care does not appear to be exceptional within the current  
31 corporate transformation of the profession and thus is inherently no more or less ethical than this  
32 current trend that has penetrated health care and the practice of medicine far beyond interactions  
33 with private equity. As Fuse Brown and Hall point out, “PE investment in health care is just the  
34 latest manifestation of the long trend of increasing commercialization of medicine. And so long as  
35 the U.S. treats health care as a market commodity, profit-seeking will persist” [1].  
36

37 Ikrum et al provide a balanced view of the situation and offer some recommendations for  
38 partnering with private equity in health care:

39  
40 While PE involvement in health care delivery invokes inherent concerns, it has provided  
41 much-needed capital for many primary care practices to mitigate the effects of the  
42 pandemic and to potentially undertake care delivery innovations such as population health  
43 management under value-based payment models. To make partnerships with private  
44 investors work, providers need to select the right investors, establish strategies upfront to  
45 address misaligned objectives, and define a successful partnership by setting goals for and  
46 transparently reporting on indicators that reflect both financial and clinical performance.  
47 Safeguards and regulations on sales may also protect patients and providers [7].

## 1 RELEVANT LAWS

2  
3 Fuse Brown and Hall write that despite the market consolidation that results from private  
4 equity acquisitions within health care, these acquisitions generally go unreported and  
5 unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-  
6 Rodino (HSR) Act and that there are currently no legal guidelines for assessing the collective  
7 market effects of add-on acquisitions. However, they do note:

8  
9 Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade  
10 Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers  
11 and acquisitions where the effect of the transaction may be “substantially to lessen  
12 competition, or to tend to create a monopoly.” To determine whether a transaction may  
13 threaten competition, antitrust agencies analyze whether the transaction will enhance  
14 the market power of the transacting parties in a given geographic and product market.  
15 [...] Typically, the FTC oversees health care acquisitions (other than insurance) [1].  
16

17 To protect patients from harmful billing practices, the federal government has passed the No  
18 Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most  
19 states have similar laws, such as those barring fee-splitting and self-referral, and several states  
20 have passed laws regulating or restricting the use of gag clauses in physician contracts. The  
21 FTC has also recently proposed a rule banning noncompete clauses in all employment  
22 contracts [1].  
23

24 The federal Emergency Medical Treatment and Labor Act (EMTALA) ensures that hospitals  
25 with an emergency department provide all patients access to emergency services regardless of  
26 their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58%  
27 of community hospitals, provide some level of charity care as a condition for their tax-exempt  
28 status, which the Internal Revenue Service (IRS) defines as “free or discounted health services  
29 provided to persons who meet the organization’s eligibility criteria for financial assistance and  
30 are unable to pay for all or a portion of the services” [19].  
31

## 32 RELEVANT AMA POLICY PROVISIONS

33  
34 Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and  
35 venture capital investment in health care, and its recommendations were adopted as Policy [H-  
36 160.891](#), “Corporate Investors.” This policy delineates 11 factors that physicians should consider  
37 before entering into partnership with corporate investors, including alignment of mission, vision,  
38 and goals; the degree to which corporate partners may require physicians to cede control over  
39 practice decision making; process for staff representation on the board of directors and medical  
40 leadership selection; and retaining medical authority in patient care and supervision of  
41 nonphysician practitioners.  
42

43 Our AMA further developed and published materials to assist physicians contemplating partnering  
44 with private equity and venture capital firms:  
45

- 46 • [Venture Capital and Private Equity: How to Evaluate Contractual Agreements](#)
- 47 • [Model Checklist: Venture Capital and Private Equity Investments](#)
- 48 • [Snapshot: Venture Capital and Private Equity Investments](#)

Policy [H-310.901](#), “The Impact of Private Equity on Medical Training,” encourages GME training institutions and programs to “demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition” and asserts that our AMA will “[s]upport publicly funded independent research on the impact that private equity has on graduate medical education.”

#### RELEVANT *CODE* PROVISIONS

The AMA *Code of Medical Ethics* [Opinion 11.2.1](#), “Professionalism in Health Care Systems,” acknowledges that “[p]ayment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians” and offers recommendations for physicians within leadership positions regarding the ethical use of payment models that influence where and by whom care is delivered. Key elements include the need for transparency, fairness, a primary commitment to patient care, and avoiding overreliance on financial incentives that may undermine physician professionalism.

[Opinion 11.2.2](#), “Conflicts of Interest in Patient Care,” clearly states: “[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. [...] When the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.”

[Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” stipulates that physicians’ fundamental ethical obligation to patient welfare requires physicians to carefully consider any contract to deliver health care services they may enter into to ensure they do not create untenable conflicts of interest. The opinion states that physicians should negotiate or remove “any terms that unduly compromise physicians’ ability to uphold ethical standards.” However, it should be acknowledged that physicians have little leverage in changing entire payment structures or reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians in private practice often feel that they have little leverage in negotiating the sale of their practice; they simply receive an offer and are told they can take it or leave it.

[Opinion 11.2.3.1](#), “Restrictive Covenants,” states: “[c]ovenants-not-to-compete restrict competition, can disrupt patient care, and may limit access to care” and that physicians should not enter into covenants that “[u]nreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship”. However, many hospitals and hospital systems today now routinely include noncompete clauses as part of their physician contracts. These clauses put physicians at risk of violation of professional obligations and their widespread use has the potential to undermine the integrity of the profession as a whole.

#### ETHICAL ANALYSIS

The ethical concerns raised by private equity investments in health care are not unique but instead represent ethical dilemmas that exist due to the very nature of treating health care as a commodity. While private equity firms may choose to pursue financial incentives that are counter to the physicians’ ethical and professional responsibilities, private equity’s investment in health care is not inherently unethical. However, caution is warranted so it is crucial that policy guidelines be developed to ensure that private equity-acquired hospitals, hospital systems, and physician practices continue to function in an ethical manner that prioritizes patients and patient care over profits. Policies that require greater transparency and disclosure of data on private equity ownership, greater state regulatory control over private equity acquisitions, closing payment and billing loopholes, rules requiring an independent clinical director on the Board of private equity

firms engaged in health care, and means for physicians to help set goals and measure outcomes to ensure the alignment of corporate and clinical values should be considered [7].

Though the current literature is conflicting, there are valid concerns that private equity investment in health care might negatively impact patient outcomes. Since serious potential risks and conflicts of interest do exist, it is essential for physicians considering entering into partnership with private equity firms to evaluate their contracts and require that the agreements are consistent with the norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an employee of a private equity-owned hospital should ensure that their contract does not place them in an untenable conflict of interest or compromise their ability to fulfill their ethical and professional obligations to patients [8].

It is the conclusion of the Council on Ethical and Judicial Affairs (CEJA) that new ethics guidance specifically addressing private equity investment in health care is not needed. There already exists rich House policy and AMA published materials addressing private equity investments in health care. Furthermore, the ethical issues that private equity involvement raise are not limited to that specific sphere of health care investment. In light of the fact that private equity is not unique in the ethical concerns it raises, the Council finds that existing guidance in [Opinion 11.2.2](#), “Conflicts of Interest in Patient Care,” and [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” are sufficient at the present time to address the concerns raised by the increasing investment by private equity in health care; however, it may be appropriate to amend current guidance to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

## RECOMMENDATIONS

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 by addition and deletion 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 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 interest or compromise their ability to fulfill their ethical and professional 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, investment firms, or other entities—they should be mindful that while ~~many some~~ some other arrangements have the potential to promote desired improvements in care, ~~some other~~

1 arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere  
2 with physician autonomy.

3  
4 When ~~contracting~~ partnering with entities, or having a representative do so on their behalf, to  
5 provide health care services, physicians should:

6  
7 (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and  
8 ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the  
9 arrangement:

10  
11 (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms,  
12 financial or performance incentives, restrictions on care, or other mechanisms intended  
13 to influence physicians' treatment recommendations or direct what care patients  
14 receive, in keeping with ethics guidance;

15  
16 (ii) does not compromise the physician's own financial well-being or ability to provide  
17 high-quality care through unrealistic expectations regarding utilization of services or  
18 terms that expose the physician to excessive financial risk;

19  
20 (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

21  
22 (iv) includes a mechanism to address grievances and supports advocacy on behalf of  
23 individual patients;

24  
25 (v) is transparent and permits disclosure to patients.

26  
27 (vi) enables physicians to have significant influence on, or preferably outright control of,  
28 decisions that impact practice staffing.

29  
30 (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability  
31 to uphold ethical or professional standards.

32  
33 When entering into contracts as employees, preferably with the advice of legal and ethics  
34 counsel, physicians must:

35  
36 (c) Advocate for contract provisions to specifically address and uphold physician ethics and  
37 professionalism.

38  
39 (d) Advocate that contract provisions affecting practice align with the professional and ethical  
40 obligations of physicians and negotiate to ensure that alignment.

41  
42 (e) Advocate that contracts do not require the physician to practice beyond their professional  
43 capacity and provide contractual avenues for addressing concerns related to good practice,  
44 including burnout or related issues.

45  
46  
47 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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

CEJA Report 4-A-24

Subject: Physicians' Use of Social Media for Product Promotion and Compensation  
(Resolution 25, A-22)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(, MD, Chair)

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

This report by the Council on Ethical and Judicial Affairs (CEJA) explores ethical issues posed by this use of social media and reviews existing guidance in the AMA *Code of Medical Ethics (Code)*.

## BACKGROUND

Resolution 025 details the recent phenomenon of physicians' involvement in promotions and endorsements on social media. While Resolution 025 is limited to the context of physicians promoting non-health related products through social media, this report encompasses the issue broadly in the contexts of promoting both non-health related and/or health related products. The concept of social media has changed dramatically in the last couple of decades and has altered how consumer goods and services are advertised, promoted, and sold. Social media now accounts for a broad range of communication—e.g., Tik Tok, Instagram, Facebook, X (formerly Twitter), YouTube—that can reach millions of people, and now often involves "influencing", where individuals promote or sell goods and services or promote themselves (e.g. their personality or lifestyle) as a financial venture.

## ETHICAL CONCERNS

Physicians' and medical students' sale and promotion of products or services and use of social media raises several ethical concerns. (1) These practices may damage the patient-physician relationship. If patients feel pressured to purchase products or services, this may undermine the trust that grounds patient-physician relationships, since it raises questions about whether physicians are fulfilling their fiduciary duty to put patients' interests above their own financial interests. (2) If inappropriate pressure is applied, then selling and promotion of products may result in the exploitation of patient vulnerability. (3) If physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable

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value, then they may put patient well-being and the integrity of the profession in jeopardy in the interest of profit-making.

#### Welfare of the Patient and the Patient-Physician Relationship

The sale and promotion of goods and services by physicians has the potential to negatively affect the welfare of patients. If a physician puts their financial interests above the interests of the patients, then this undercuts the foundational ethical principle that physicians must regard their “responsibility to the patient as paramount. [Principle VIII]. In addition, since patients are “vulnerable and dependent on the doctor’s expertise” and there is an “asymmetry of knowledge” between patients and physicians, there is a risk that patients may be exploited and this, in turn, can “undermine a patient’s trust” [1]. Further, if patients find out about a physician’s financial incentive to recommend certain products or services after the fact, they may feel that they have been purposefully deceived, and so have reason to distrust both that individual physician and the profession as a whole. It is therefore imperative that physicians conscientiously distinguish when they are acting in their professional capacity by recommending products or services intended for patient benefit or public health, and when they are acting as commercial agents independent of their professional identity.

#### Integrity of the Profession

Physician sales and promotion of products and services may also damage the integrity of the profession. Physicians have an ethical duty to uphold professional standards in their role as physician in all areas of life. A key principle of professional integrity is that physicians should recognize that they carry the authority of their professional role with them into other social spheres. Physicians “engage in a number of roles” which include conveyors of information, advocates, experts, and commentators on medically related issues [2]. For many physicians, “navigating successfully among the potentially overlapping roles ...poses challenges.” [2] Physicians “carry with them heightened expectations as trusted...representatives of the medical profession.” [2] Physicians should be aware that these expectations cannot be entirely separated from their personal identity either online or elsewhere and should take care to curate their social media presence accordingly.

#### PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

The concept of social media has changed since the technology’s first appearance and widespread adoption. Today, social media platforms are broadly internet-enabled technologies that enable individuals to have a presence online and ability to share opinions and self-generated media content to a wide audience.

Opinion 2.3.2 “Professionalism in Social Media” reflects an outdated understanding of the types and uses of social media, modeling its guidance on traditional sites such as Facebook, where the primary purposes are social networking among friends and colleagues, and perhaps also disseminating beneficial public health messages. While guidance that addresses these uses is still necessary (and so should be retained), modifications are required to reflect the fact that social media can now be used as a form of marketing intended to financially benefit individuals and corporations. The ethical concerns that arise in this context mirror those that arise in other situations where physicians are selling and promoting goods and services, that is, use of social media by medical professionals can undermine trust and damage the integrity of patient-physician relationships and the profession as a whole when physicians inappropriately use their social media presence to promote personal interests.

1 CONCLUSION

2  
3 Updating 2.3.2 “Professionalism in the Use of Social Media” so that it includes guidance on using  
4 social media to sell and promote products makes it clear that the consolidated guidance clearly  
5 applies to the concerns raised in Resolution 025. Revising this also provides an opportunity to  
6 update language to reflect the current realities of technology and contemporary business practices.  
7

8 RECOMMENDATION

9  
10 In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:  
11 Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as  
12 follows and the remainder of this report be filed:  
13

14 Social media—internet-enabled communication platforms—enable individual medical students  
15 and physicians to have both a personal and a professional presence online. Social media can  
16 foster collegiality and camaraderie within the profession as well as provide opportunities to  
17 widely disseminate public health messages and other health communications. However, use of  
18 social media by medical professionals can also undermine trust and damage the integrity of  
19 patient-physician relationships and the profession as a whole, especially when medical students  
20 and physicians use their social media presence to promote personal interests.  
21

22 Physicians and medical students should be aware that they cannot realistically separate their  
23 personal and professional personas entirely online and should curate their social media  
24 presence accordingly. Physicians and medical students therefore should:  
25

- 26 (a) When publishing any content, consider that even personal social media posts have the  
27 potential to damage their professional reputation or even impugn the integrity of the  
28 profession.  
29  
30 (b) Respect professional standards of patient privacy and confidentiality and refrain from  
31 publishing patient information online without appropriate consent.  
32  
33 (c) Maintain appropriate boundaries of the patient-physician relationship in accordance with  
34 ethics guidance if they interact with their patients through social media, just as they would  
35 in any other context.  
36  
37 (d) Use privacy settings to safeguard personal information and content, but be aware that once  
38 on the Internet, content is likely there permanently. They should routinely monitor their  
39 social media presence to ensure that their personal and professional information and  
40 content published about them by others is accurate and appropriate.  
41  
42 (e) Publicly disclose any financial interests related to their social media content, including, but  
43 not limited to, paid partnerships and corporate sponsorships.  
44  
45 (f) When using social media platforms to disseminate medical health care information, ensure  
46 that such information is useful and accurate based on professional medical judgment.  
47

48 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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

CEJA Report 5-A-24

Subject: CEJA's Sunset Review of 2014 House Policies

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of  
2 American Medical Association (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

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1 the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies  
2 and Practices.

3  
4 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

5  
6 6. Sunset policies will be retained in the AMA historical archives.

7  
8 RECOMMENDATION

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

Fiscal Note: Less than \$500.

## APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
<a href="#">H-140.898</a>	Medical Profession Opposition to Physician Participation in Execution	Our AMA strongly reaffirms its opposition to physician participation in execution.	Retain; remains relevant.
<a href="#">H-140.950</a>	Physician Participation in Capital Punishment	<p>Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following:</p> <p>(1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.</p> <p>(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.</p> <p>(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.</p> <p>Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.</p> <p>(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians</p>	Retain; remains relevant.

		who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician.	
<a href="#">H-140.963</a>	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
<a href="#">H-140.999</a>	Our AMA and Bioethics	Our AMA requests official representation on any federal advisory committee or commission dealing with ethical issues of interest to medicine.	Retain; remains relevant.
<a href="#">H-140.963</a>	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
<a href="#">H-265.992</a>	Expert Witness Testimony	Our AMA: (1) encourages each state medical society to work with its state licensing board toward the development of effective disciplinary measures for physicians who provide fraudulent testimony; (2) provides legal and advocacy support to those medical and specialty organizations who seek to devise programs designed to discipline physicians for unprofessional conduct relative to expert witness testimony; (3) continues to study and work with interested organizations to address the inherent difficulties in conducting the peer review of physicians who provide expert witness testimony; (4) continues to educate physicians about ethical guidelines and professional responsibility regarding the provision of expert witness testimony; (5) encourages each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process. (6) encourages each state medical society to assist its state licensing board in the peer review process of expert witnesses by providing an expert witness committee program similar to the one in the state of Florida; (7) works with the Federation of State Medical Boards to address problems regarding out-of-state expert witnesses; and	Retain; remains relevant.



		(8) acts as a clearinghouse for advice and support as the state medical associations develop their own expert witness committee programs.	
<a href="#">H-270.961</a>	Medical Care Must Stay Confidential	Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.	Retain; remains relevant.
<a href="#">H-405.958</a>	Physician Right to Conscience	Our AMA supports high standards of civility and respect among physicians amidst differing political beliefs, aspects of conscience and ethical views because debate and expression of disagreement is healthy and essential to the improvement of medicine, and physicians should communicate any differences in a civil and professional manner.	Retain; remains relevant.
<a href="#">H-65.997</a>	Human Rights	Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(A-24)

Introduced by: Integrated Physician Practice Section

Subject: Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the significance and incidence of physician and healthcare workforce burnout and  
2 workplace stress has increased dramatically; and  
3

4 Whereas, burnout among healthcare professional has shown to negatively impact the quality of  
5 care, patient safety, and healthcare system operations; and  
6

7 Whereas, there are many individual, systemic, and collective factors that contribute to physical  
8 and mental health and, therefore, a sense of wellbeing or lack thereof, which may increase the  
9 likelihood of burnout; and  
10

11 Whereas, there is ongoing research to identify and better understand workplace and individual  
12 stresses that contribute to burnout and can diminish an individual's sense of wellbeing; and  
13

14 Whereas, individual health history and biological data can provide valuable insights into physical  
15 and mental health, and the collection and use of personal and biological data offer potential  
16 avenues to support the wellbeing of healthcare professionals, including the early identification of  
17 burnout and developing prevention strategies; and  
18

19 Whereas, the use of such data must be done in a manner that respects individual privacy rights  
20 and ethical considerations; and  
21

22 Whereas, the healthcare community currently lacks comprehensive, standardized guidelines for  
23 the ethical collection and use of this data in the context of workforce wellbeing; and  
24

25 Whereas, the management of such sensitive data raises significant privacy, security, and ethical  
26 issues that must be carefully addressed to ensure the rights and interests of individuals are  
27 protected; therefore be it  
28

29 RESOLVED, that our American Medical Association monitor and report on the research  
30 regarding technology, measures, and effective use of personal and biological data which  
31 supports professional workforce wellbeing and mitigates burnout (Directive to Take Action); and  
32 be it further  
33

34 RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of  
35 personal and biological data for the professional workforce (Directive to Take Action).  
36

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

Received: 4/17/2024

## RELEVANT AMA POLICY

### 9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

[AMA Principles of Medical Ethics: I,II,IV](#)

Citation: Issued: 2016

### Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmed: A-22

### **Factors Causing Burnout H-405.948**

Our AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

Citation: Res. 208, I-22

### **Physician Health Programs H-405.961**

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of: Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 402, A-12; Modified: BOT Rep. 15, A-19

### **Physician Burnout D-405.972**

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Citation: Res. 723, A-22; Reaffirmed: I-22

### **Peer Support Groups for Second Victims D-405.980**

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the "second victim phenomenon"; and (2) will work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" on our physician workforce.

Citation: Res. 702, A-19

### **Programs on Managing Physician Stress and Burnout H-405.957**

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

### **Physicians and Family Caregivers: Shared Responsibility H-210.980**

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;

(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

Citation: Res. 308, I-98; Reaffirmed: A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

### **Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993**

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

Citation: Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and Appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18

### **Study of Medical Student, Resident, and Physician Suicide D-345.983**

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

Citation: CME Rep. 06, A-19; Modified: Res. 326, A-22

### **Resident/Fellow Clinical and Educational Work Hours H-310.907**

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
  - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
  - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
  - c) Use, where possible, recommendations from respective specialty societies and evidence-based

approaches to any future revision or introduction of clinical and educational work hour rules.

d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:

a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.

c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.

d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).

b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.

c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."

f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.

g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.

i) Scheduled time providing patient care services of limited or no educational value should be minimized.

j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.

k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmed: A-22

### **Physician and Medical Staff Member Bill of Rights H-225.942**

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

#### **Preamble**

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

#### **From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:**

##### **I. Our AMA recognizes the following fundamental responsibilities of the medical staff:**

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

**II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:**

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

**III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:**

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

**IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:**

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.



- g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
- h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMD Rep. 5, A-21; Reaffirmed: A-22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002  
(A-24)

Introduced by: Medical Student Section and Resident & Fellow Section

Subject: Removal of the Interim Meeting Resolution Committee

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, AMA Bylaws 2.12.1.1 and 2.13.13 indicate that the Interim Meeting Resolution  
2 Committee limits consideration of resolutions to those that pertain to “advocacy and legislation”  
3 or “ethics” or that “requir[e] action prior to the following Annual Meeting”; and  
4

5 Whereas, six months after the Board of Trustees recommended formation of the Resolution  
6 Committee, the Report of the Executive Vice President at Interim 2002 (I-02) noted that “while I  
7 appreciate the need to streamline, I strongly believe that everything the AMA does is advocacy,”  
8 and elaborated that “this includes activities you might not initially view as advocacy, like the  
9 public stands we take on issues of public health and science”<sup>1</sup>; and  
10

11 Whereas, over the course of 8 years between I-12 and I-19 (up till the implementation of Special  
12 Meetings during COVID), the average number of resolutions historically not considered based  
13 on Resolution Committee recommendations was less than 7<sup>2</sup>; and  
14

15 Whereas, from I-12 to I-19, the small number of items historically not considered based on  
16 Resolution Committee recommendations ranged from 2 to 10 (2 at I-19, 8 at I-18, 4 at I-17, 3 at  
17 I-16, 9 at I-15, 8 at I-14, 10 at I-13, and 9 at I-12)<sup>2</sup>; and  
18

19 Whereas, the low number of resolutions historically screened out by the Interim Meeting  
20 Resolution Committee indicates that the House has successfully managed its volume of  
21 business without significant benefit from the Resolution Committee; and  
22

23 Whereas, despite perceptions of increased resolution volume, we have concluded business  
24 early at all 4 HODs since returning from COVID, including a full day earlier at A-23; and  
25

26 Whereas, the use of the Interim Meeting Resolution Committee functionally means that  
27 resolutions relating to meeting operations, Bylaws, task forces, and other organizational  
28 initiatives and resolutions requesting studies should be withheld until the Annual Meeting, as  
29 they would be unlikely to meet Resolution Committee criteria, unnecessarily delaying regular  
30 functions of our HOD and AMA until those resolutions can be introduced in June; and  
31

32 Whereas, the Resolution Committee does not meet at all to deliberate, as each member  
33 individually and privately simply checks off whether they approve a resolution; and  
34

35 Whereas, no criteria exist for whether resolutions should be considered if they relate to reports  
36 or to other resolutions approved for consideration, leading to unclear rationale for decisions; and  
37

38 Whereas, even resolutions clearly related to advocacy, ethics, or urgency (including titles  
39 mentioning “Policy Reform,” “Regulation,” names of specific legislation, or issues pending

1 imminent Congressional votes or executive agency decisions with time-limited comment  
2 periods) are regularly screened out, leading to unclear rationale for decisions; and  
3

4 Whereas, while a majority vote can consider a screened-out resolution, smaller and newer  
5 delegations are at baseline disadvantaged in overturning a negative decision, which conflicts  
6 with democratic principles of fairness and protection of minority rights and views, a central tenet  
7 of our House's parliamentary procedure to ensure all voices are heard; and  
8

9 Whereas, many delegations' advocacy priorities were negatively affected by the narrow  
10 resolution criteria at I-23 and several, not just the MSS and RFS, attempted extractions; and  
11

12 Whereas, the removal of the Resolution Committee could better balance the load between the  
13 Interim and Annual Meetings, rather than the Annual Meeting seeing an increased load due to  
14 resolution resubmissions, which also leads to increased report load at subsequent Annual  
15 Meetings for resolutions that were referred a year prior; and  
16

17 Whereas, while the Interim Meeting is a day shorter, we still concluded business early the last  
18 two years, many screened-out resolutions would likely be handled agreeably by Reference  
19 Committees without extraction, and our House already uses other ways to effectively self-  
20 regulate volume of debate (e.g., calling the question, shortening testimony time); and  
21

22 Whereas, better methods to manage a modest increase in Interim Meeting business, without  
23 needing to extend the meeting, could include using the same number of Reference Committees  
24 as the Annual Meeting, since the Interim Meeting currently only uses 6 and the Annual  
25 Meeting's 8 Reference Committees more evenly distribute additional business across additional  
26 sessions on both Saturday afternoon and Sunday morning; therefore be it  
27

28 RESOLVED, that our American Medical Association remove the Resolution Committee from  
29 Interim Meetings by amending AMA Bylaw B-2.13.3, "Resolution Committee," by deletion as  
30 follows:  
31

32 **Resolution Committee. B-2.13.3**

33 ~~The Resolution Committee is responsible for reviewing resolutions~~  
34 ~~submitted for consideration at an Interim Meeting and determining~~  
35 ~~compliance of the resolutions with the purpose of the Interim~~  
36 ~~Meeting.~~

37 ~~2.13.3.1 Appointment. The Speaker shall appoint the members of~~  
38 ~~the committee. Membership on this committee is restricted to~~  
39 ~~delegates.~~

40 ~~2.13.3.2 Size. The committee shall consist of a maximum of 31~~  
41 ~~members.~~

42 ~~2.13.3.3 Term. The committee shall serve only during the meeting~~  
43 ~~at which it is appointed, unless otherwise directed by the House of~~  
44 ~~Delegates.~~

45 ~~2.13.3.4 Quorum. A majority of the members of the committee shall~~  
46 ~~constitute a quorum.~~

47 ~~2.13.3.5 Meetings. The committee shall not be required to hold~~  
48 ~~meetings. Action may be taken by written or electronic~~  
49 ~~communications.~~

50 ~~2.13.3.6 Procedure. A resolution shall be accepted for~~  
51 ~~consideration at an Interim Meeting upon majority vote of committee~~  
52 ~~members voting. The Speaker shall only vote in the case of a tie. If~~

~~a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~

~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker. (Modify Bylaws); and be it further~~

RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1, "Business of Interim Meeting," by deletion as follows:

**~~2.12.1.1 Business of Interim Meeting~~**

~~The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting. (Modify Bylaws)~~

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

Received: 4/19/2024

**REFERENCES**

1. Report of the Executive Vice President, American Medical Association Interim 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
2. American Medical Association Archives. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.

**RELEVANT AMA Policy**

**B-11.1 Parliamentary Procedure**

In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

**G-600.054 Procedures of the House of Delegates**

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
  - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
  - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.

3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly. [Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17]

#### **G-600.060 Introducing Business to the AMA House**

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House. [Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(A-24)

Introduced by: Medical Student Section

Subject: Amendments to AMA Bylaws to Enable Medical Student Leadership  
Continuity

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, terms on the Medical Student Section (MSS) Governing Council, as the medical  
2 student member on an AMA Council or the AMA Board of Trustees, or as the MSS  
3 representative on the Minority Affairs Section or Women Physicians Section Governing Councils  
4 are one year in length and commence after the Annual Meeting; and  
5

6 Whereas, the AMA Bylaws defining cessation of eligibility for these positions state that if the  
7 medical student leader “graduates from an educational program within 90 days prior to an  
8 Annual Meeting,” they shall be permitted to continue to serve “until the completion of the Annual  
9 Meeting”; and  
10

11 Whereas, some students graduate off-cycle during the fall semester rather than the spring  
12 semester, including some in November, over 180 days prior to the AMA Annual Meeting; and  
13

14 Whereas, graduation off-cycle is more common for students with disabilities or chronic illness,  
15 students who have taken leave of absence for personal or familial reasons, students who have  
16 overcome medical or personal challenges, students from underrepresented backgrounds,  
17 students who have pursued unique opportunities, and students who have faced obstacles  
18 during their educational journey; and  
19

20 Whereas, students who graduate off-cycle would technically be forced under the AMA Bylaws to  
21 vacate their AMA national leadership position, leading to discontinuity of Medical Student  
22 Section leadership, disrupting MSS internal operations and priorities, and curtailing these  
23 students’ opportunity to grow as leaders; and  
24

25 Whereas, the MSS Assembly has repeatedly unanimously expressed their desire that students  
26 who graduate off-cycle should be able to complete their leadership terms; therefore be it  
27

28 RESOLVED, that our American Medical Association amend AMA Bylaws 3.5.6.3, 6.11, 7.3.2,  
29 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section  
30 Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section  
31 Representatives on other Governing Councils for up to 200 days after graduation. (Modify  
32 Bylaws)  
33

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

Received: 4/5/2024

**RELEVANT AMA POLICY****Medical Student Trustee - Cessation of Enrollment B-3.5.6.3**

The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

**Term of Resident/Fellow Physician or Medical Student Member B-6.11**

A resident/fellow physician or medical student member of a Council who completes residency or fellowship or who graduates from an educational program within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

**Medical Student Section - Cessation of Eligibility B-7.3.2**

If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

**Minority Affairs Section - Section Representatives on the Governing Council B-7.7.3.1**

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 ceases to meet the membership requirement of the respective section.

**Women Physicians Section - Section Representatives on the Governing Council B-7.10.3.1**

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 ceases to meet the membership requirement of the respective section.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(A-24)

Introduced by: Thomas W. Eppes, MD, Mark D. Townsend, MD MHCM, and Billie L. Jackson, MD.

Subject: The Rights of Newborns that Survive Abortion

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, our American Medical Association recognizes healthcare as a human right; and

2  
3 Whereas, the AMA has policy 2.2.4(d) Treatment Decisions for the Seriously Ill Newborn, which  
4 states, "Initiate life sustaining and life enhancing treatment when the child's prognosis is largely  
5 uncertain"; and

6  
7 Whereas, AMA Code 2.2.1(I) calls on the physician to seek consultation when there is a  
8 reversible life-threatening condition and the patient (If capable) or parents or guardian refuses  
9 treatment the physician believes is clearly the patient's best interest (ii) there is disagreement  
10 about what the patient's best interest is; and

11  
12 Whereas, CDC data shows from 2003-14 at least 143 babies died after being born alive after an  
13 abortion procedure, but did not count newborns that survived attempted abortions; and

14  
15 Whereas, the number of children that live after an abortion procedure is only reported now by  
16 anecdotal reports; and

17  
18 Whereas, cited in the Annotations section of the Code of Ethics, "Children Not Meant to Be:  
19 Protecting the Interests of the Child When Abortion Results in Live Birth", 6 Quinnipiac Health  
20 states in conclusion that "in these situations, abortive parents and physicians should not solely  
21 decide the child's best interests."; therefore be it

22  
23 RESOLVED, that our American Medical Association amend the current policy right for an  
24 abortion to "a woman's right to abortion as only the right to terminate the pregnancy" (Modify  
25 Current HOD Policy); and be it further

26  
27 RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical  
28 care. (New HOD Policy)

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

Received: 4/23/2024



**Relevant AMA Policy:****AMA Policy 2.2.4 Treatment Decisions for Seriously Ill Newborns**

Making treatment decisions for seriously ill newborns is emotionally and ethically challenging for both parents and health care professionals. Decisions must take into account the newborn's medical needs; the interests, needs, and resources of the family; and available treatment options. Decision makers must also assess whether the choice made for the newborn will abrogate a choice the future individual would want to make for him- or herself, i.e., whether the choice will undermine the child's right to an "open future." Providing information and other resources to support parents or guardians when they must make decisions about their child's care and future is a key responsibility for physicians and other health care professionals.

Decisions not to initiate care or to discontinue an intervention can be emotionally wrenching in any circumstance, but may be particularly so for a seriously ill newborn. Physicians are in a position to help parents, families, and fellow professionals understand that there is no ethical difference between withholding and withdrawing treatment—when an intervention no longer helps to achieve the goals of care or promote the quality of life desired for the patient, it is ethically appropriate to withdraw it.

To help parents formulate goals for their newborn's care and make decisions about life-sustaining treatment on their child's behalf, physicians should:

- a. Inform the parents about available therapeutic options, the nature of available interventions, and their child's expected prognosis with and without treatment.
- b. Help the parents formulate goals for care that will promote their child's best interests in light of:
  - i. the chance that the intervention will achieve the intended clinical benefit;
  - ii. the risks involved with treatment and nontreatment;
  - iii. the degree to which treatment can be expected to extend life;
  - iv. the pain and discomfort associated with the intervention; and
  - v. the quality of life the child can be expected to have with and without treatment.
- c. Discuss the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a given amount of time to determine whether the intervention has led to improvement. Confirm that if the intervention has not achieved agreed-on goals, it may be withdrawn. Physicians should recognize, and help parents appreciate, that it is not necessary to have prognostic certainty to withdraw life-sustaining treatment, since prognostic certainty is often unattainable and may unnecessarily prolong the infant's suffering.
- d. Initiate life-sustaining and life-enhancing treatment when the child's prognosis is largely uncertain.
- e. Adhere to good clinical practice for palliative care when life-sustaining treatment is withheld or withdrawn.
- f. Provide access to counseling services or other resources to facilitate decision making and to enable parents opportunity to talk with others who have had to make similar decisions.
- g. Seek consultation through an ethics committee or other institutional resource when disagreement about the appropriate course of action persists.

**AMA Policy 2.2.1 Pediatric Decision Making**

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and

parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

- a. Provide compassionate, humane care to all pediatric patients.
- b. Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- c. Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- d. Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- e. Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.
- f. When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
- g. When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
- h. When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005  
(A-24)

Introduced by: Mississippi

Subject: AMA Executive Vice President

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, our American Medical Association (AMA) is the most powerful voice for physicians in  
2 the nation; and  
3

4 Whereas, the Executive Vice President (EVP) of the AMA is thus a position of extreme  
5 importance to the physician community; and  
6

7 Whereas, the tradition of our AMA has been to have a physician EVP; and  
8

9 Whereas, our AMA should select the most qualified physician leader possible for the EVP  
10 position; and  
11

12 Whereas, at any given time that best physician leader may be serving or have recently served in  
13 the AMA physician leadership; and  
14

15 Whereas, physician leaders who are serving or recently served in AMA leadership are  
16 sometimes the most knowledgeable and experienced in addressing the current issues facing  
17 the House of Medicine; and  
18

19 Whereas, many physician leaders serving in the AMA would be extremely qualified candidates  
20 for the AMA EVP based on their AMA leadership experience and their own medical practice and  
21 medical administration leadership experiences; and  
22

23 Whereas, the Mississippi State Medical Association (MSMA) had a similar situation and was  
24 able to hire a physician and past President and Chair of the Board of our MSMA as our  
25 Executive Director during a difficult time for our organization; and  
26

27 Whereas, the MSMA board wanted the ability to hire the best qualified candidate as Executive  
28 Director without the restriction even if they had served or were currently serving in a leadership  
29 role at MSMA; and  
30

31 Whereas, physicians who may be serving or have recently served in the AMA physician  
32 leadership as an officer or trustee are currently ineligible for consideration for the AMA EVP  
33 position under AMA Code Section B-5.3.6.4 until three years after their AMA service; and  
34

35 Whereas, no comparable physician or health care organization has such a strict limitation on  
36 who can be considered for their EVP position; therefore be it  
37

38 RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties  
39 and Privileges Code B-5.3.6.4 as follows:

- 1 ~~No individual who has served as an AMA officer or trustee shall be selected or serve as~~
- 2 ~~Executive Vice President until three years following completion of the term of the AMA office.”~~
- 3 (Modify Bylaws)

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

Received: 4/23/2024

## RELEVANT AMA POLICY

### Board of Trustees

#### Duties and Privileges. B-5.3

In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006  
(A-24)

Introduced by: Missouri

Subject: Treatment of Family Members

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the code of ethics of the American Medical Association (AMA) was written in the 19th  
2 century AD; and  
3

4 Whereas, the practice of medicine has taken giant steps since then in areas of diagnostic  
5 testing, medical records recordings, patient safety measures, documentations, verifications,  
6 consents, hospitals and outpatients credentialing of surgeons and procedurists, etc.; and  
7

8 Whereas, concerns about appropriateness of care, indications, and proper training of physicians  
9 performing a procedure, or a physician treating any patient has become a legal and ethical  
10 process witnessed by office, hospital, and medical facilities' staff including medical and non-  
11 medical personnel recording, and reviewing appropriateness of care besides the treating  
12 physicians; and  
13

14 Whereas, multiple documented surveys of specialists and PCPs showed that a large number of  
15 these physicians admitted treating family members when they felt comfortable and confident  
16 they can provide the best care for them; and  
17

18 Whereas, a much larger percentages of plastic, head and neck surgeons, dermatologists, have  
19 admitted treating their family members; and  
20

21 Whereas, the current code of ethics, as it is currently written, sadly label these physicians acts  
22 as unethical; and  
23

24 Whereas, many hospitals, and surgery centers have "discovered" lately this part of the code of  
25 ethics, and started enforcing it, therefore forcing the physicians to seek other venues to treat  
26 family members; and  
27

28 Whereas, rendering care or performing procedures outside approved facilities such as an  
29 uncredited office procedure room or un-accredited other facilities endanger the life and well-  
30 being of the patients; and  
31

32 Whereas, physicians ultimate concern is their patient's safety and wellbeing whether the patient  
33 is a family member, a staff person, a friend or none of these; therefore be it  
34

35 RESOLVED, that our American Medical Association asks CEJA to review and revise the current  
36 code of ethics as it relates to treating family members (Directive to Take Action); and be it  
37 further  
38

39 RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim  
40 meeting I-24. (Directive to Take Action)

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

Received: 4/24/2024

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007  
(A-24)

Introduced by: American Association of Public Health Physicians

Subject: AMA Supports a Strategy for Eliminating Nuclear Weapons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, AMA policies concerning weapons, which were modified last in 2015, voice clear  
2 “opposition to nuclear war” (Ref 1) and support for “the elimination by all nations of nuclear  
3 weapons and other weapons of mass and indiscriminate destruction” (Ref 2); and  
4

5 Whereas, millions have been sickened or killed by nuclear weapons testing around the world  
6 since 1945, yet the United Nation’s Comprehensive Nuclear Test Ban Treaty, adopted by the  
7 UN General Assembly in 1996 and ratified by 178 countries as of March 2024, has failed to  
8 enter into force because the United States and other nuclear weapons possessing countries  
9 have not ratified it and because, ominously, Vladimir Putin’s government withdrew its ratification  
10 in 2023 (Ref 3); and  
11

12 Whereas, AMA policy supports a “comprehensive nuclear test ban” and encourages the US  
13 Government to “to continue the process of bilateral and verifiable nuclear arms reduction”, (Ref  
14 4 & 5) but that process has stalled; and  
15

16 Whereas, seventy-six years after the 1945 bombs that killed hundreds of thousands of innocent  
17 civilians in Japan, the United Nation’s Treaty of the Prohibition of Nuclear Weapons at last  
18 became international law in 2021, though the Treaty is not ratified yet by any country that  
19 possesses nuclear weapons, (Ref 6); and  
20

21 Whereas, the US government plans to spend \$1.7-3 trillion over the next thirty years to update  
22 its thousands of nuclear bombs and delivery systems, money that the concepts of intersectional  
23 justice (Ref 7) dictate should be better spent on healthcare, education, housing and other  
24 needs; and  
25

26 Whereas, a strategy towards implementing the Treaty on the Prohibition of Nuclear Weapons  
27 has been enunciated (Ref 8); and  
28

29 Whereas, this strategy has been endorsed by hundreds of local governments, civil society  
30 organizations, and medical organizations, including the Maine Medical Association, American  
31 Public Health Association, Physicians for Social Responsibility, and Union of Concerned  
32 Scientists, (Ref 9); and  
33

34 Whereas, the ongoing conflicts in Ukraine, the Middle East, and the Indo-Pakistani region  
35 involving nuclear weapons possessing countries are raising the risk of an intentional or  
36 accidental nuclear war with devastating health consequences; therefore be it  
37

38 RESOLVED, that our American Medical Association calls for the United States and the other  
39 nuclear weapons states to sign and ratify the United Nations Treaty on the Prohibition of



1 Nuclear Weapons and to pursue good-faith negotiations on effective measures relating to the  
2 cessation of the nuclear arms race (Directive to Take Action); and be it further  
3

4 RESOLVED, that our AMA calls for the United States to renounce the option to be the first  
5 country to use nuclear weapons ("first use") during a conflict (Directive to Take Action); and be it  
6 further  
7

8 RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely  
9 the President, are required to approve a nuclear attack, while still allowing a swift response  
10 when needed (New HOD Policy); and be it further  
11

12 RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire  
13 nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of  
14 nuclear weapons and delivery systems. (Directive to Take Action)  
15

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

Received: 4/24/2024

#### REFERENCES

1. H-520.999 Opposition to Nuclear War  
The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.
2. H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction  
The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.
3. [https://en.wikipedia.org/wiki/Comprehensive\\_Nuclear-Test-Ban\\_Treaty](https://en.wikipedia.org/wiki/Comprehensive_Nuclear-Test-Ban_Treaty) Accessed 3.28.2024
4. H-520.994 Nuclear Test Ban  
The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban
5. D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War  
Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.  
Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.
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#### RELEVANT AMA POLICY

##### **H-520.999 Opposition to Nuclear War**

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.

Citation: (Sub. Res. 82, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: Res. 524, A-15)

##### **H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction**

The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.

Res. 617, I-96 Reaffirmed: CLRPD Rep. 2, A-06 Reaffirmed: Res. 524, A-15

**H-520.994 Nuclear Test Ban**

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban.

Res. 90, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: Res. 524, A-15

**D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War**

1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.

2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.

Res. 436, A-05 Appended: Res. 524, A-15

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008  
(A-24)

Introduced by: Barbara L. McAneny, MD

Subject: Consolidated Health Care Market

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the American Medical Association has long warned the nation about the problems  
2 that can be associated with a consolidated health care market and has opposed insurance  
3 company mergers; and  
4

5 Whereas, Optum acquired Change Health over the objections of the Federal Trade  
6 Commission; and  
7

8 Whereas, on February 21, 2024, Optum and Change Health suffered a ransomware attack and  
9 shut down all operations, including the electronic claims submission, electronic remittance, prior  
10 authorization and documentation of patient eligibility; and  
11

12 Whereas, across the country, medical practices, hospitals, pharmacies and many other health  
13 care businesses had their revenue cycle disrupted, and cash flow interrupted, putting their  
14 economic viability at risk; and  
15

16 Whereas, Optum and its parent company United Health Group continued to collect premiums  
17 and had the opportunity to retain significant amounts of money as no claims were being paid,  
18 and therefore had the opportunity to collect interest and investment gains on money that should  
19 have been paid to practices and other entities, raising the question of unjust enrichment; and  
20

21 Whereas, Optum is the largest employer of physicians and has acquired practices when the  
22 ransomware disruption made those practices unable to survive without acquisition; and  
23

24 Whereas, even the practices that survive will have ongoing damages including but not limited to  
25 denials related to giving therapy when it was impossible to obtain prior authorization, from using  
26 lines of credit and having to pay interest, from having billing departments and others work  
27 overtime to submit claims, to losing key employees from inability to make payroll; and  
28

29 Whereas, oncology practices were particularly hard hit because of the need to purchase  
30 chemotherapy without being able to be paid for the chemotherapy and are being charged late  
31 payments for those purchases; and  
32

33 Whereas, the AMA has a long history of defending practices against unfair business practices  
34 by insurance companies and their subsidiaries; therefore be it  
35

36 RESOLVED, that our American Medical Association investigate the possibility of filing a class  
37 action lawsuit against Optum, United Health Group and Change Health to recoup the damages  
38 from the disruption caused by the breach, and to distribute the unfair enrichment profits made  
39 by Optum et al to the practices whose retained payments allowed them to generate interest and  
40 investment profits (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of
- 2 the breach and determine if the independence of those practices can be resurrected, and if not,
- 3 if damages are due to the physician owners of the acquired practices. (Directive to Take Action)

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

Received: 4/24/2024

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009  
(A-24)

Introduced by: Resident and Fellow Section

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, current AMA policy includes gendered language such as “mother” and “pregnant woman” when discussing families and persons in need of obstetric and gynecologic care such as in H-20.917, H-320.954, H-420.950, H-420.962, H-420.969, and more; and

Whereas, the Human Rights Campaign (HRC) definition of “family” when used in hospital visitation policy is stated as: “‘Family’ means any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual. Members of ‘family’ include spouses, domestic partners, and both different-sex and same-sex significant others. ‘Family’ includes a minor patient’s parents, regardless of the gender of either parent.”<sup>1</sup>; and

Whereas, in 2022 the American College of Obstetricians and Gynecologists (ACOG) published a policy statement stating “To be inclusive of women and all patients in need of obstetric and gynecologic care, ACOG will move beyond the exclusive use of gendered language and definitions”<sup>1</sup>; and

Whereas, the World Professional Association for Transgender Health (WPATH)’s *Standards of Care - version 8*, published in 2022, includes guideline 1.2 which states that “We recommend health care professionals use language in health care settings that uphold the principles of safety, dignity, and respect”<sup>3</sup>; and

Whereas, AMA policy H-65.942, adopted in June 2023, strongly encourages the use of gender-neutral language supports the use of gender-neutral language in AMA policies and communications, but as written this policy does not apply to other resources the AMA creates and distributes; therefore be it

**RESOLVED**, that our American Medical Association review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures. (Directive to Take Action)

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

Received: 4/24/2024

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2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>. Published February 2022. Accessed April 17, 2023.

3. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wespe, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

### Relevant AMA Policy:

#### HIV/AIDS and Substance Abuse H-20.903

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

#### Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918

In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

- (1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.
- (2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
- (3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.
- (4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

### **Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918**

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.

2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.

3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.

4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. [Res. 428, A-16]

### **Reducing Lead Poisoning H-60.924**

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current

weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level  $>5 \mu\text{g/dL}$  ( $>50 \text{ ppb}$ ) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level  $>1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above  $1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

### **Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973**

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.

2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. [Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

### **Humanitarian and Medical Aid Support to Ukraine D-65.984**

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]



**Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961**

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

**Addiction and Unhealthy Substance Use H-95.976**

Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

- (1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
- (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
- (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
- (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
- (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
- (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
- (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
- (8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. [BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19]

**Mercury and Fish Consumption: Medical and Public Health Issues H-150.947**

AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. [CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15]

**AMA Support for Breastfeeding H-245.982**

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages

public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

#### **Accommodating Lactating Mothers Taking Medical Examinations H-295.861**

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

#### **Protecting Trainees' Breastfeeding Rights D-310.950**

Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. [Res. 302, I-16]

#### **Post-Partum Hospital Stay and Nurse Home Visits H-320.954**

The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of

the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

#### **Substance Use Disorders During Pregnancy H-420.950**

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected. [Res. 209, A-18; Modified: Res. 520, A-19]

#### **Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. [Res. 102, A-12; Modified: Res. 503, A-17]

#### **Shackling of Pregnant Women in Labor H-420.957**

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

#### **Perinatal Addiction - Issues in Care and Prevention H-420.962**

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

**Fetal Alcohol Syndrome Educational Program H-420.964**

Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

**Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968**

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Legal Interventions During Pregnancy H-420.969**

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:

- (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
- (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
- (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
- (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
- (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
- (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

**AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

**Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992**

Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. [Res. 504, A-17]

### **Bonding Programs for Women Prisoners and their Newborn Children H-430.990**

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

### **7.3.4 Maternal-Fetal Research**

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. [Issued: 2016]

### **Supporting the Use of Gender-Neutral Language H-65.942**

Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies<sup>1</sup> internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. [Res. 602, A-23]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012  
(A-24)

Introduced by: Mississippi

Subject: Ethical Pricing Procedures that Protect Insured Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, healthcare organizations that provide direct care (such as clinics, pharmacies,  
2 hospitals, and the like) are operating on increasingly small profit margins and many are on the  
3 brink of bankruptcy; and  
4

5 Whereas, the health insurance industry as a whole is consistently posting significant profits; and  
6

7 Whereas, many health insurance companies are publicly traded and, thusly, their directors hold  
8 a fiduciary duty to their shareholders to make decisions based on the company's best financial  
9 interests for the end of increased profit margins without sufficient regard to the beneficiaries (the  
10 insureds) that pay for their services; and  
11

12 Whereas, the process of pricing medications for consumers is increasingly complicated,  
13 involving many middlemen and questionable practices that are not disclosed to the public under  
14 the guise of "proprietary means"; and  
15

16 Whereas, this complicated process has been manipulated by health insurance companies,  
17 pharmaceutical manufacturers, pharmacy benefit managers, and other stakeholders to  
18 negotiate terms that offer benefits for themselves without sufficient regard to the best interests  
19 of their insured patients; and  
20

21 Whereas, under the current system, insured patients pay a monthly premium in good faith  
22 believing that their health insurer will arrange for medications to be bought by them (the  
23 insureds) at a lower cost point than could otherwise be achieved without insurance or some  
24 other non-paid service; and  
25

26 Whereas, the current system has betrayed the aforementioned good faith of the insured patients  
27 by utilizing a pricing process that results in higher prices to the patient for many medications  
28 than could be achieved without insurance coverage (cash price) or with the aid of a free  
29 "discount card" (such as GoodRX); and  
30

31 Whereas, this betrayal of the insured patients' good faith represents a flaw of the system that is  
32 woefully unethical and should be identified as such by insureds as well as their advocates (the  
33 House of Medicine) and should be addressed by lawmakers for consumer and patient  
34 protection; and  
35

36 Whereas, physicians are a cornerstone in the House of Medicine and, by nature of their  
37 profession, are fierce patient advocates, safeguarding the patient's best interests; and  
38

39 Whereas, the American Medical Association (AMA) is the most prominent and powerful unified  
40 voice of Physicians; therefore be it

1 RESOLVED, that our American Medical Association advocate for policies that limit the cost of a  
2 medication to an insured patient with medication coverage to the lower range of prices that a  
3 non-covered patient can achieve at cash price either before or after application of a non-  
4 manufacturer's free discount card (such as GoodRx) (Directive to Take Action); and be it further  
5

6 RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders  
7 describing the ethical dilemma of the medication pricing process and how it adversely affects  
8 insured patients. (Directive to Take Action)  
9

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013  
(A-24)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, each year 3.6 million<sup>1</sup> individuals give birth in the United States and 3 million people  
2 are lactating; and  
3

4 Whereas, 70% of pregnant and lactating people<sup>2</sup> take some kind of medication when they are  
5 pregnant or lactating; and  
6

7 Whereas, pregnant and lactating people are generally excluded in clinical research<sup>3</sup>, there is a  
8 dearth of data about the appropriate safety, dosage, and efficacy of most medical interventions  
9 in pregnant and lactating individuals; and  
10

11 Whereas, the lack of data results in patients and clinicians choosing to (a) forego an intervention  
12 which may result in harm from an un(der) treated condition or (b) use an intervention which may  
13 carry an uncertain risk of harm for an unknown potential benefit; and  
14

15 Whereas, lack of access to research exacerbates health inequities in pregnant and lactating  
16 individuals<sup>4</sup>; and  
17

18 Whereas, the harm from excluding pregnant individuals from clinical research was very  
19 apparent during the COVID-19 pandemic and contributed to vaccine hesitancy and resulted in  
20 unnecessary and avoidable maternal and infant mortality and morbidity<sup>5,6,7</sup>; and  
21

22 Whereas, recent initiatives from the White House<sup>8</sup>, National Institutes of Health<sup>9</sup>, and the  
23 National Academies of Science, Engineering, and Medicine<sup>10</sup> have emphasized the need for  
24 further research in pregnant and lactating individuals; and  
25

26 Whereas, the American College of Obstetricians and Gynecologists<sup>11</sup>, National Academies of  
27 Science, Engineering, and Medicine<sup>10</sup>, and the U.S. Department of Health and Human Services  
28 have moved from an overly protectionist ethic that prioritizes minimization of fetal risk to one  
29 that recognizes the scientific, legal, and ethical complexities of research including the risks to  
30 the pregnant/lactating individual, fetus, and/or neonate of NOT doing research; and  
31

32 Whereas, the HHS Task Force on Research Specific to Pregnant Women and Lactating Women  
33 released detailed recommendations, along with an implementation plan, to protect pregnant and  
34 lactating individuals through research, rather than from research<sup>12,13</sup>; and  
35

36 Whereas, as this national policy discussion unfolds, the ethical guidance of our profession must  
37 undergird this discussion; and



Whereas, the existing Code of Medical Ethics Opinion 7.3.4 Maternal-Fetal Research extracts content from both the Code modernization process of 2016 with foundational original material stemming from the “Medical applications of fetal tissue transplantation” opinion passed in 1989; and

Whereas, much in women’s health, research infrastructure, ethical frameworks, and liability landscape has changed since 1989 and the ethics of research in lactation is not discussed in the Code; therefore be it

RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs consider updating its ethical guidance on research in pregnant and lactating individuals. (Directive to Take Action)

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

Received: 4/24/2024

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## **RELEVANT AMA POLICY**

### **7.3.4 Maternal-Fetal Research**

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nongravid human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014  
(A-24)

Introduced by: New England

Subject: The Preservation of the Primary Care Relationship

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, large health systems are restricting access to specialty care unless patients change  
2 their primary care physician to a physician, physician associate (PA), or nurse practitioner (NP)  
3 employed by their system, resulting in the extreme disruption of well-established patient  
4 physician relationships; and

5  
6 Whereas, the Institute of Medicine has declared that continuity is foundational to the  
7 effectiveness of the patient physician relationship in primary care, with decades of research  
8 concluding that coordination of care is essential to building a trusting relationship<sup>1</sup>; and

9  
10 Whereas, the Commonwealth Fund and the Agency for Healthcare Research and Quality  
11 underscore the critical role of high-quality primary care in enhancing health system  
12 effectiveness, advocating for increased financial investment, shifting to hybrid or capitated  
13 payment approaches, and emphasizing the adoption of patient-centered medical homes to  
14 address existing challenges and ensure accessibility, efficiency, and quality in healthcare<sup>2,3</sup>; and

15  
16 Whereas, maintaining outpatient continuity with a primary care physician reduces emergency  
17 department use and hospitalizations, lowers costs, and increases patient and physician  
18 satisfaction, while discontinuity is linked to higher post discharge costs and readmission rates<sup>4,5</sup>;  
19 and

20  
21 Whereas, value-based care contracting financially incentivizes systems to “capture” large  
22 numbers of patients which has led to the practice of large health systems coercing patients to  
23 abandon their primary care physician of choice, establishing with one of their employed  
24 physicians, NPs or PAs in order to access specialty care; and

25  
26 Whereas, hospital consolidations have also been scrutinized for boosting costs, narrowing  
27 access, and potentially impacting care quality, where these consolidations can lead to increased  
28 prices and may not necessarily improve the quality of care patients receive<sup>6</sup>; and

29  
30 Whereas, due to national and regional differences in access to both specialty and primary care,  
31 in addition to variations in the expansiveness of large health care systems, there is a lack of  
32 transparency and data on the impact of these restrictive practices and necessitates further  
33 study<sup>7</sup>; and

34  
35 Whereas, there is a current crisis in healthcare with limited access to primary care and certain  
36 specialties, further, given this limited access, it is important that patients are able to obtain care  
37 across networks, and limiting this access harms both the patients and the physicians; and

Whereas, CEJA Report 1-A-01, The Patient-Physician Relationship, states that “The medical profession must strive to preserve the trust patients hold in their physicians. It cannot abandon ethical standards to economic force”<sup>8</sup>; therefore be it

RESOLVED, that our American Medical Association opposes health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care (New HOD Policy); and be it further

RESOLVED that our AMA requests the Council on Ethical and Judicial Affairs review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for policies that promote patient choice, ensure continuity of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives. (Directive to Take Action)

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

Received: 5/7/2024

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#### RELEVANT AMA POLICY

##### **Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901**

Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

##### **Disease Management and Demand Management H-285.944**

The AMA strongly encourages health insurance plans and managed care organizations that provide disease management to involve the patient's current primary or principal care physician in the disease management process as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings.

1.1.1 Patient-physician relationships--background reports\_0.pdf (ama-assn.org)

Relevant AMA Correspondences

RE: The Acquisition of Aetna, Inc. by CVS Health Corporation 2018, to the United States Department of Justice

We are writing to provide our views regarding the proposed merger of CVS Health Corporation (CVS), the largest retail pharmacy chain and specialty pharmacy in the U.S. and one of the two largest pharmacy benefit managers (PBM), and Aetna, Inc. (Aetna), the third largest U.S. health insurer. The AMA has studied this merger, an analysis that started almost as soon as the merger was officially announced. The AMA has sought the views of prominent health economists, health policy and antitrust experts—some of whom testified in a California Department of Insurance hearing on this merger. After very carefully considering this merger over the past months, the AMA has come to the conclusion that this merger would likely substantially lessen competition in many health care markets, to the detriment of patients. Accordingly, based on the mutually confirming analyses and conclusions presented by the nationally recognized experts and other experts, as well as extensive research, the AMA is now convinced that the proposed CVS-Aetna merger should be blocked.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015  
(A-24)

Introduced by: New England

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing  
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and  
3 social determinants of health — to eliminate disparities in health and health care<sup>1</sup>; and  
4

5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is  
6 essential to optimizing health care access and the quality of patient care; and  
7

8 Whereas, many barriers remain and unique challenges persist for some diverse groups  
9 attempting to enter the medical field and successfully matriculate through the profession of  
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and  
11

12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%  
13 identified as Hispanic, and ~5.0% identified as Black or African American<sup>2</sup>; and  
14

15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in  
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American  
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to  
18 increase by 26% by 2030<sup>3,4</sup>; and  
19

20 Whereas, black people account for roughly 13 percent of the US population, they make up only  
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when  
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These  
23 representational disparities have not changed appreciably in decades;<sup>3,4</sup> and  
24

25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates  
26 of remedial intervention and dismissal from their programs than their White counterparts, thus  
27 leading to concerns of over-policing in medical education; and  
28

29 Whereas, over-policing in education begins as early as primary school and continues through  
30 high school, college, medical education, and into the workforce. In graduate medical  
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in  
32 the residency selection process;<sup>5</sup> and  
33

34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly  
35 20% of those who were dismissed in 2015;<sup>7</sup> and  
36

37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms  
38 of depression and anxiety among minority students, residents and physicians. This often leads

1 to reducing practice hours or leaving medicine, creating even greater workforce  
2 disparities;<sup>5</sup> therefore be it  
3

4 RESOLVED, that our American Medical Association further study and track the prevalence of  
5 attending physicians' and trainees' dismissals and remedial interventions, based on race,  
6 gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities  
7 (Directive to Take Action); and be it further  
8

9 RESOLVED, that our AMA engage stakeholders to study and report back how to effectively  
10 support underrepresented groups in medicine to level the playing field for those most affected  
11 by bias and historical harms (Directive to Take Action); and be it further  
12

13 RESOLVED, that our AMA work with stakeholders to make recommendations on a review and  
14 appeals process that will enable physicians and trainees to receive a fair and equitable due  
15 process in defense of alleged shortcomings. (Directive to Take Action)  
16

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

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#### RELEVANT AMA POLICY

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

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed

care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

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

### **Continued Support for Diversity in Medical Education D-295.963**

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

Res. 325, A-03 Appended: CME Rep. 6, A-11 Modified: CME Rep. 3, A-13 Appended: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Appended: Res. 319, A-22 Modified: Res. 319, A-23

### **Diversity in the Physician Workforce and Access to Care D-200.982**

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-21

### **Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area



Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14

Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18

Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19

Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23

American Medical Association House of Delegates

Resolution: 016  
(A-24)

Introduced by: New York

Subject: Guiding Principles for the Healthcare of Migrants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, there has been a recent increase in migrants and asylum seekers in the United States  
2 that has garnered New York City, New York State and National media attention <sup>1</sup>; and  
3

4 Whereas, this recent increase in migrants and asylum seekers has overwhelmed multiple areas  
5 of the United States, including southern border states such as Texas and Arizona, and has  
6 resulted in their coordinated transportation to cities that have “right to shelter” laws, such as  
7 New York City, Chicago, Denver and Washington D.C. <sup>2,3</sup>, and  
8

9 Whereas, from April 2022 to December 2023, more than 150,000 migrants have arrived in New  
10 York City;<sup>1</sup> and  
11

12 Whereas, the Mayor of the City of New York declared an “Asylum Seeker State of Emergency”  
13 on 10/7/22, calling for increased aid from State and Federal governments<sup>4</sup>; and  
14

15 Whereas, the 2022-2023 New York City budgets did not account for this recent increase in  
16 migrants and asylum seekers, yet New York City has attempted to divert adequate resources to  
17 the New York City Health and Hospital System, which operates the Humanitarian Emergency  
18 Response and Relief Centers (HERRCs) which process the intake, screening, shelter,  
19 healthcare and other needs of migrants and asylum seekers <sup>5</sup>; and  
20

21 Whereas, the diversion of funds from the New York City budget to HERRCs and other  
22 associated costs of the recent increase in migrants and asylum seekers has resulted in a  
23 decreased funding of other New York City municipal services, such as public libraries, public  
24 schools and law enforcement<sup>6</sup>; and  
25

26 Whereas, New York State has declared a Disaster Emergency via Executive Order No. 28.7 in  
27 response to the recent increase in migrants and asylum seekers in New York State <sup>7</sup>, and  
28

29 Whereas, despite a \$1 Billion addition to the New York State 2024 Budget allocated for  
30 response for migrants and asylum seekers, as well as mobilization of 1,500 National Guard  
31 Members and an Executive Order mobilizing additional resources, the New York State Governor  
32 is requesting additional support and resources from the Federal Government, including FEMA,  
33 the U.S. Department of Defense, and the National Parks Service <sup>8, 9, 10</sup>; and  
34

35 Whereas, New York City has become so financially overwhelmed with the recent increase in  
36 migrants and asylum seekers that it has requested discontinuation of its “right to shelter”  
37 statutes, and has reverted to litigating bus transportation companies for costs associated with  
38 the healthcare and housing of asylum seekers they have brought <sup>11, 12</sup>; and

Whereas, Federal legislators are considering massive overhauls to immigration policy, but only at the expense of continued financial aid in the international conflict between Russia and Ukraine <sup>13</sup>; and

Whereas, having adequate policy regarding the guiding principles of the healthcare for migrants and asylum seekers will allow organized medicine groups to adequately respond to future legislation or executive actions regarding the present migration crisis and future migration issues; and

Whereas, the First District Branch of MSSNY has “RESOLVED, that the First District Branch will collaborate together to write a resolution ... to advocate for increased federal funding, and other federal solutions, to address the public health needs of the recent 2023 increase in asylum-seeking migrants.”, but has no other standing policy on migrants and asylum seekers; and

Whereas, the Medical Society of the State of New York does not have any present relevant policy regarding providing healthcare for migrant and asylum seekers, and

Whereas, the American Medical Association policy D-350.975 “Immigration Status is a Public Health Issue” does recognize “immigration status is a public health issue” and “will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities”, and AMA policy H-350.957 “Addressing Immigrant Health Disparities” addresses a limited scope of issues related to the healthcare of migrants, without reference to many important principles and priorities as identified by the World Health Organization <sup>14, 15, 16, 17</sup>; and

Whereas, while the current migrant crisis being faced in the United States is causing recent local, state and national attention to this issue, other groups dedicated to the study and policy development of the healthcare of migrants at the international level report that this is indeed a part of a larger global migration trend, with the World Health Organization noting that from “2000 - 2017, the total number of international migrants rose from 173 million to 258 million, an increase of 49%” <sup>16</sup>; and

Whereas, migrants face many unique health challenges and vulnerabilities including but not limited to; inadequate access to healthcare, increased need for mental health services, inadequate disease prevention, inadequate provision of care, lack of financial protection, discrimination, language and cultural barriers, increased risk of encountering communicable diseases, poor access to vaccination, inadequate continuity of care, inadequate health record portability, food insecurity, malnutrition, sexual and gender-based violence including abuse and trafficking and unsafe work conditions <sup>16</sup>, therefore be it

RESOLVED, that our American Medical Association advocate for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement” (Directive to Take Action); and be it further

RESOLVED, that our AMA recognizes that migration status is a social determinant of health (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms the importance of multi-sectoral coordination and inter-  
2 country engagement and partnership in enhancing the means of addressing health aspects of  
3 migration (New HOD Policy); and be it further  
4

5 RESOLVED, that our AMA recognizes that the enhancement of migrants' health status relies on  
6 an equitable and non-discriminatory access to and coverage of health care and cross-border  
7 continuity of care at an affordable cost avoiding severe financial consequences for migrants, as  
8 well as for their families (New HOD Policy); and be it further  
9

10 RESOLVED, that our AMA recognizes that investment in migrant health provides positive  
11 dividends compared to public health costs due to exclusion and neglect, and therefore  
12 underscore the need for financing mechanisms that mobilize different sectors of society,  
13 innovation, identification and sharing of good practices in this regard, and be it further  
14

15 RESOLVED, that our AMA recognizes that the promotion of the physical and mental health of  
16 migrants as defined by the following select objectives from the World Health Organization's  
17 72nd World Health Assembly, Global action plan on promoting the health of refugees and  
18 migrants, 2019-2023, is accomplished by  
19

- 20 1. Ensuring that essential components, such as vaccination of children and adults and the  
21 provision of health promotion, disease prevention, timely diagnosis and treatment,  
22 rehabilitation and palliative services for acute, chronic and infectious diseases, injuries,  
23 mental and behavioral disorders, and sexual and reproductive health care for women,  
24 are addressed.  
25
- 26 2. Improving the quality, acceptability, availability and accessibility of health care services,  
27 for instance by overcoming physical, financial, information, linguistic and other cultural  
28 barriers, with particular attention to services for chronic conditions and mental health,  
29 which are often inadequately addressed or followed up during the migration and  
30 displacement process, and by working to prevent occupational and work-related  
31 diseases and injuries among migrant workers and their families by improving the  
32 coverage, accessibility and quality of occupational and primary health care services and  
33 social protection systems.  
34
- 35 3. Ensuring that the social determinants of migrants' health are addressed through joint,  
36 coherent multisectoral actions in all public health policy responses, especially ensuring  
37 promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible  
38 migration and mobility of people, including through implementation of planned and well-  
39 managed migration policies, as defined in the Sustainable Development Goals of the  
40 United Nations.  
41
- 42 4. Ensuring that information and disaggregated data at global, regional and country levels  
43 are generated and that adequate, standardized, comparable records on the health of  
44 migrants are available to support policy-makers and decision-makers to develop more  
45 evidence-based policies, plans and interventions.  
46
- 47 5. Providing accurate information and dispelling fears and misperceptions among migrant  
48 and host populations about the health impacts of migration and displacement on migrant  
49 populations and on the health of local communities and health systems. (New HOD  
50 Policy)

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

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American Medical Association House of Delegates

Resolution: 017  
(A-24)

Introduced by: New York

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, in the wake of the recent Harvard Anatomical Donation scandal, there is a clear need  
2 to reform rules and regulations surrounding the use of anatomical specimens in medical  
3 education, anthropological study, and related disciplines; and <sup>1,2,3</sup>  
4

5 Whereas, America has a long and well-documented history of exploitation against American  
6 Indians, Alaska Natives, people of color, immigrants, those with disabilities, incarcerated people,  
7 non-Christian, and poor citizens, who historically have not been afforded the same rights as  
8 white, able-bodied Americans; and <sup>4-7</sup>  
9

10 Whereas, preserved and skeletal anatomical specimens from as far back as the 1800s are still  
11 held by medical schools and used for educational purposes today; and <sup>8-12</sup>  
12

13 Whereas, the need for anatomical specimens has long since outpaced supply now and even  
14 more in the distant past; and <sup>13</sup>  
15

16 Whereas, in the 1800s the theft of the bodies of minority populations like that of indigenous,  
17 enslaved, and free Black citizens was a common practice increasing supply of anatomical  
18 specimens without attracting scrutiny from legal entities; and <sup>14-16</sup>  
19

20 Whereas, some institutions have begun decommissioning, cremating, or returning remains of  
21 some slaves or minority populations; and <sup>17-19</sup>  
22

23 Whereas, other institutions have fought to hold on to remains like those of mother Bessie  
24 Wilborn, who had Paget's disease, whose skeleton still hangs at the University of Georgia  
25 against the wishes of her family; and <sup>20-21</sup>  
26

27 Whereas, despite laws such as the Native American Graves and Repatriation Act, which  
28 "requires federal agencies and institutions that receive federal funding to return Native American  
29 "cultural items" to lineal descendants and culturally affiliated American Indian tribes, Alaska  
30 Native villages, and Native Hawaiian organizations", museums and institutions of higher  
31 learning have not complied with these laws; and <sup>30, 31</sup>  
32

33 Whereas, Harvard holds human remains of 19 likely enslaved individuals and thousands of  
34 Native Americans according to a recent report <sup>29-30</sup>; and  
35

36 Whereas, the Peabody Museum at Harvard stewards a collection of hair samples, and often  
37 names, taken from Indigenous people including clippings of hair from approximately 700 Native  
38 American children attending federal Indian Boarding Schools<sup>29</sup>; and

Whereas, the final manifestation of medical racism is the use of patient's bodies without their consent and the repatriation of these specimens is an important step toward healing minorities' distrust in medicine<sup>21</sup>; and

Whereas, today many states have presumed consent laws that still allow for bodies that haven't been claimed in as short as few days to be donated for dissection; and <sup>27, 28</sup>

Whereas, the majority of unclaimed bodies are non-white person, persons with mental health issues, or are the bodies of low- income individuals; and <sup>26-28</sup>

Whereas, the medical ethics community in America has expressed concern about presumed consent in the case of organ donation due to potential for damage the relationship of trust between clinicians caring for patients at the end of life and their families and loss of autonomy especially amongst those least capable of registering objections; and <sup>25, 26</sup>

Whereas, AMA Code of Ethics 6.1.4. cautions against the practice of presumed consent for deceased organ donation, but the AMA has no current policy on what constitutes ethical consent processes for donation of cadavers or body parts following death for educational purposes; and

Whereas, AMA Code of Ethics 6.1.3 provides guidelines on financial incentives for cadaveric donations; however both opinions were developed in reports in 2002 and 2005 respectively, and do not consider the issues from a lens of medical racism; and

Whereas, MSSNY recently passed comprehensive new policy at its 2024 HOD calling for several actions to address the historical injustices of anatomical specimen use in NY State and for forwarding proposed policy to the AMA; therefore be it

RESOLVED, that Our American Medical Association advocate to AAMC (Association of American Medical Colleges) and other appropriate bodies for the return of human remains to living family members, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments; as required by laws such as the Native American Graves and Repatriation Act (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of Black and Brown people and other minority groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains (Directive to Take Action); and be it further

RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups (Directive to Take Action); and be it further

1 RESOLVED, that Our AMA support the creation of a national anatomical specimen database  
2 that includes registry demographics (New HOD Policy); and be it further

3  
4 RESOLVED, that our AMA study and develop recommendations regarding regulations for  
5 ethical body donations including, but not limited to guidelines for informed and presumed  
6 consent; care and use of cadavers, body parts, and tissue (Directive to Take Action); and be it  
7 further

8  
9 RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for  
10 Organs from Deceased Donors should be amended as follows:

- 11 ○ Physicians who propose to develop or participate in pilot studies of presumed  
12 consent or mandated choice should ensure that the study adheres to the  
13 following guidelines:
  - 14 ■ (a) Is scientifically well designed and defines clear, measurable outcomes  
15 in a written protocol.
  - 16 ■ (b) Has been developed in consultation with the population among whom  
17 it is to be carried out.
  - 18 ■ (c) Has been reviewed and approved by an appropriate oversight body  
19 and is carried out in keeping with guidelines for ethical research.
- 20 ○ ~~Unless there are data that suggest a positive effect on donation, n~~ Neither  
21 presumed consent nor mandated choice for cadaveric organ donation should be  
22 widely implemented.

23 (Modify Current HOD Policy); and be it further

24  
25 RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical  
26 specimens, tissues and other human material that were collected and maintained for purposes  
27 of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed  
28 consent has been obtained are consistent with the goals of this resolution, and that  
29 biospecimens donated for research, education, and transplantation with informed consents of  
30 donors (or, if available, next of kin if deceased) are consistent with the goals of this resolution as  
31 such materials can advance medical knowledge, improve the quality of healthcare and save  
32 lives. (New HOD Policy)

Fiscal Note: To Be Determined

Received: 5/8/2024

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## RELEVANT AMA POLICY

### Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

### **Organ Donation and Honoring Organ Donor Wishes H-370.998**

Our AMA:

- (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members
- (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

### **Medical Ethics and Continuing Medical Education H-300.964**

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making.

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

#### **6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors**

Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

- (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
- (b) Has been developed in consultation with the population among whom it is to be carried out.
- (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.

Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018  
(A-24)

Introduced by: New York

Subject: Opposing Violence, Terrorism, Discrimination, and Hate Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the American Medical Association represents hundreds of thousands of physicians  
2 across the United States; and  
3

4 Whereas, the AMA is committed to promoting the health and well-being of all individuals and  
5 communities; and  
6

7 Whereas, the AMA recognizes the inherent dignity and worth of every person, regardless of  
8 race, ethnicity, gender, disability, religious affiliation, cultural affiliation, sexual orientation, or  
9 other factor; and  
10

11 Whereas, the AMA condemns all forms of violence, terrorism, discrimination, and hate speech  
12 perpetrated against any group or individual; and  
13

14 Whereas, the AMA acknowledges the ongoing conflicts and persecution faced by numerous  
15 groups around the world, including but not limited to:  
16

- 17 • Ethnic minorities such as the Rohingya in Myanmar, the Uighurs in China, and the Kurds
- 18
- 19 • Religious communities such as Jews, Muslims, Christians, Yazidis, etc.
- 20
- 21 • Indigenous populations
- 22
- 23 • LGBTQ+ individuals
- 24
- 25 • Refugees and asylum seekers in many countries
- 26

27 Whereas, current events including but not limited to the conflicts in the Middle East and Ukraine-  
28 Russia provide context for this resolution and demonstrate the AMA's awareness of global  
29 issues; and  
30

31 Whereas, it is imperative for the AMA to address issues of recognition and commemoration in a  
32 manner that fosters unity, understanding, and healing among all communities; therefore be it  
33

34 RESOLVED, that our American Medical Association strongly condemns all acts of violence,  
35 terrorism, discrimination, and hate speech against any group or individual, regardless of race,  
36 ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other  
37 factor (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms its commitment to promoting dialogue, empathy, and mutual  
2 respect among diverse communities, recognizing the importance of fostering understanding and  
3 reconciliation (New HOD Policy); and be it further  
4

5 RESOLVED, that our AMA recognizes the importance of commemorating and honoring the  
6 victims of tragedies throughout human history, in a manner that respects the dignity and  
7 sensitivities of all affected communities (New HOD Policy); and be it further  
8

9 RESOLVED, that our AMA encourages initiatives that promote education, awareness, and  
10 solidarity to prevent future acts of violence and promote social cohesion (New HOD Policy); and  
11 be it further  
12

13 RESOLVED, that our AMA acknowledges the diverse perspectives and experiences within its  
14 membership and commits to facilitating constructive dialogue and engagement on sensitive and  
15 polarizing issues (New HOD Policy); and be it further  
16

17 RESOLVED, that our AMA calls for continued collaboration and partnership with organizations  
18 representing diverse communities. (Directive to Take Action)  
19

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

Received: 5/8/2024

AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution 019  
(A-24)

Introduced by: Minority Affairs Section

Subject: Supporting the Health of Our Democracy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, our American Medical Association “acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric”; and

Whereas, our AMA “recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and

Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes”; and

Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and teaching hospitals facilitating nonpartisan voter registration efforts<sup>1</sup>; and

Whereas, a growing body of research demonstrates the relationship between the political determinants of health (including voter rates, government participation, and policy engagement) and other social determinants, including how votes lost to morbidity and mortality in underrepresented populations impact electoral and policy outcomes<sup>2-4</sup>; and

Whereas, lower voter rates among elderly patients, patients with disabilities, patients who are socially isolated, and low-income patients are associated with poor reported health, and increased voter rates are associated with healthier lifestyle behaviors and improved mental health, even when controlling for income inequality<sup>4-10</sup>; and

Whereas, health facilities’ nonpartisan voter registration efforts demonstrate improved civic engagement and are protected by the National Voter Registration Act and IRS code<sup>11-14</sup>; and

Whereas, emergency absentee ballot access for people experiencing or managing medical emergencies is variable across states, with only 23 offering coverage for patients’ relatives and only 17 extending protections to healthcare workers<sup>12</sup>; and

Whereas, physician voter rates are lower than the general public, often due to work conflicts, although rates are higher in states with universal mail ballots<sup>15-16</sup>; and

Whereas, President Biden’s Executive Order on Promoting Access to Voting strongly encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health Service sites to seek designation as voter registration sites<sup>17</sup>; and

Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC offer voter registration services, and the Health Resources and Services Administration even offers guidance for Federally Qualified Health Centers to organize such efforts<sup>12,18-19</sup>; and

Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian Health Programs, which are crucial interfaces with Native American patients and Tribal governments<sup>20-21</sup>; and

Whereas, gerrymandering disenfranchises voters, especially voters of color and low-income voters, resulting in electoral outcomes that do not accurately reflect popular votes and subsequent governments who often limit ballot access once in power<sup>22-24</sup>; and

Whereas, increased gerrymandering and barriers to ballot access are associated with lower life expectancies, obstruction of Medicaid expansion, and perpetuation of systemic racial health inequities, especially among Black, Latine, and Native American populations<sup>3,23-24</sup>; and

Whereas, the primary solution to gerrymandering is the creation of independent, nonpartisan redistricting commissions, so if our AMA recognizes that gerrymandering is a threat to health outcomes, then we should support solutions to mitigate this problem<sup>25</sup>; therefore be it

RESOLVED, that our American Medical Association support policies that ensure safe and equitable access to voting and opposes the institutional barriers to both the process of voter registration and the act of casting a vote (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians and medical trainees to vote, oppose barriers to their participation in the electoral process, and support their and other healthcare workers' engagement in nonpartisan voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers (New HOD Policy); and be it further

RESOLVED, that our AMA support the use of independent, nonpartisan commissions to draw districts for both federal and state elections. (New HOD Policy)

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

Date Received: 5/8/2024

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## RELEVANT AMA POLICY

### Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

**Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections D-65.982**

Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows, and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community; and (2) work with appropriate stakeholders to ensure that medical students, residents, fellows and physicians are allowed time to vote without penalty on Election Days.



AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution: 020  
(A-24)

Introduced by: Minority Affairs Section

Subject: Voter Protections During and After Incarceration

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, our American Medical Association “acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric”; and

Whereas, our AMA “recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and

Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes”; and

Whereas, states that increase access to voting experience stronger public health outcomes and better self-reported health status of individuals, while reduced access to voting has been linked to poorer health outcomes and decreased health coverage<sup>1-4</sup>; and

Whereas, barriers to voting in the United States have been associated with an increased likelihood of not having access to health care coverage, thereby making the government less accountable to the needs of its people<sup>5</sup>; and

Whereas, past expansion of suffrage resulted in improved maternal outcomes following women’s suffrage in 1920 and reduced Black infant mortality correlated with the Voting Rights Act of 1965, due to policies passed by legislators after the addition of these voters<sup>6</sup>; and

Whereas, 48 states currently restrict the right to vote of 4.6 million citizens convicted beyond a misdemeanor, and many states permanently bar them from voting<sup>7-9</sup>; and

Whereas, the Fifth Circuit Court of Appeals ruled in August 2023 that a state violated the US Constitution by inflicting cruel and unusual punishment by stripping the right to vote from citizens who were convicted<sup>10</sup>; and

Whereas, since 2020, 7 states passed laws allowing citizens to vote while on parole<sup>7</sup>; and

Whereas, Black and Latine people are imprisoned 5 times and 1.3 times as much as white people, respectively<sup>11</sup>; and

Whereas, racial inequities in incarceration extend to voter rights for citizens who are incarcerated as well, with 5.3% of Black incarcerated citizens banned compared to 1.5% of non-Black incarcerated citizens<sup>9</sup>; and

Whereas, Black men comprise over one-third of the total disenfranchised population, are disproportionately impacted by policing and overrepresented in the carceral system, and could comprise as much as 40% in states that restrict incarcerated citizens' right to vote, demonstrating that restriction of voter rights in incarceration substantially contributes to the disenfranchisement of Black citizens<sup>12</sup>; therefore be it

RESOLVED, that our American Medical Association support the continuation and restoration of voting rights for citizens currently or formerly incarcerated, support efforts ensuring their ability to exercise their vote during and after incarceration, and oppose efforts to restrict their voting rights (New HOD Policy); and be it further

RESOLVED, that our AMA research the impact of disproportionate policing in and incarceration of minoritized communities on voter participation and health outcomes (Directive to Take Action); and be it further

RESOLVED, that our AMA develop educational materials and programming to educate medical trainees and physicians on the impact of incarceration on voting and health outcomes. (Directive to Take Action)

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

Date Received: 5/8/2024

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#### RELEVANT AMA POLICY

##### Mental Illness and the Right to Vote H-65.971

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

**Support for Safe and Equitable Access to Voting H-440.805**

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

**Support for Democracy H-65.947**

Our AMA: (1) unequivocally supports the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans; (2) will strongly oppose attempts to subvert the democratic process; and (3) asserts that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021  
(A-24)

Introduced by: Minority Affairs Section

Subject: Opposition to Capital Punishment

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the principle of medicine “to help and do no harm” is related to beneficence, which  
2 speaks to the obligation of the physician to act for the benefit of the patient and remove  
3 conditions that will cause harm, and nonmaleficence, which is concerned with weighing the  
4 benefits and burdens of medical interventions and proceeding with the best choice for the  
5 patient that minimizes harm and suffering;<sup>1</sup> and  
6

7 Whereas, capital punishment, or the death penalty, is defined by the United States Bureau of  
8 Justice Statistics as “the process of sentencing convicted offenders to death for the most  
9 serious crimes (capital crimes) and carrying out that sentence” where the specific offenses are  
10 “defined by statute and are prescribed by Congress or any state legislature”;<sup>2</sup> and  
11

12 Whereas, forms of capital punishment used in the United States include electrocution, lethal  
13 injection, and firing squad;<sup>3,4</sup> and  
14

15 Whereas, 24 individuals in 5 states (Texas, Oklahoma, Missouri, Alabama, and Florida) executed  
16 in 2023;<sup>2,5</sup> and  
17

18 Whereas, supporters of capital punishment argue that the practice saves on costs of  
19 incarceration, but these arguments have also proven to be categorically false, as many states  
20 actively spend millions of additional dollars annually to uphold these policies;<sup>6-10</sup> and  
21

22 Whereas, 23 states have abolished capital punishment without significant changes in crime or  
23 murder rates, challenging the argument that it effectively deters serious crimes;<sup>11-17</sup> and  
24

25 Whereas, in response to drug shortages, manufacturing changes, high cost, and manufacturer  
26 reluctance to sell drugs for execution, prisons are introducing novel forms of capital punishment  
27 including nitrogen hypoxia and midazolam (in lieu of phenobarbital), in addition to attempts to  
28 procure drugs for lethal injection from illegal and untraceable sources;<sup>18-20</sup> and  
29

30 Whereas, current methods of capital punishment used in the United States have been  
31 associated with severe, distressful symptoms, in addition to the inherent harm caused by the act  
32 of capital punishment itself;<sup>21-23</sup> and  
33

34 Whereas, nitrogen hypoxia is opposed as a use of euthanasia by the American Veterinary  
35 Medical Association due to its ability to cause distress in nonhuman animals;<sup>24</sup> and  
36

37 Whereas, the threshold for an acceptable amount of suffering in humans is widely considered to  
38 be lower than for suffering in nonhuman animals;<sup>25</sup> and  
39

40 Whereas, the AMA’s amicus brief in the 2018 Supreme Court case *Bucklew v. Precythe* relating

to novel forms of capital punishment states “Society wants to delude itself into a belief that capital punishment no longer represents a weighted moral choice, but is now somehow scientific—nearly antiseptic. This delusion, however, cheapens life and makes its extinction easier. The medical profession, whose ‘essential quality’ is an interest in humanity and which reveres human life should have no part in this charade.”;<sup>26</sup> and

Whereas, AMA Code of Medical Ethics Opinion 9.7.3 Capital Punishment states clearly that “as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution”; and

Whereas, AMA Code 9.7.3 only addresses physician participation in executions and does not address the AMA’s advocacy stance on capital punishment, so an attempt to change the AMA’s advocacy stance on this issue does not require an amendment to the Code; therefore be it

RESOLVED, that our American Medical Association amend H-140.896, “Moratorium on Capital Punishment,” by addition and deletion as follows:

**Opposition to Moratorium on Capital Punishment H-140.896**

Our AMA: (1) opposes all forms of ~~does not take a position~~ on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process.

(Modify Current HOD Policy)

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

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## RELEVANT AMA Policy

### H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. [Sub. Res. 8, A-01; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17]

### Code of Medical Ethics 9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner. These include, but are not limited to:
  - (d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
  - (e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.
  - (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that

are part of the execution procedure.

- (g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
- (h) Attending or observing an execution as a physician.
- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (j) Selecting injection sites.
- (k) Starting intravenous lines as a port for a lethal injection device.
- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
- (m) Inspecting, testing, or maintaining lethal injection devices.
- (n) Consulting with or supervising lethal injection personnel. 20

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if:

- (u) The decision to donate was made before the prisoner's conviction.
- (v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
- (w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. [AMA Principles of Medical Ethics: I; Issued: 2016]

#### **H-140.950 Physician Participation in Capital Punishment**

Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following: (1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed. (2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins. (3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements. Treatment should be provided in a properly-secured, general medical or psychiatric facility, not

in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician. [CEJA Rep. 6, A-95; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14; Reaffirmed in lieu of Res. 7, A-14]

#### **H-140.898 Medical Profession Opposition to Physician Participation in Execution**

Our AMA strongly reaffirms its opposition to physician participation in execution. [Res. 10, A-02; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

#### **D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols**

Our AMA will remind all state medical societies to review their state execution statutes to ensure that physician participation is not required. [Res. 3, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20]

#### **H-140.963 Secrecy and Physician Participation in State Executions**

The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution. [Res. 6, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022  
(A-24)

Introduced by: Minority Affairs Section

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing  
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and  
3 social determinants of health — to eliminate disparities in health and health care<sup>1</sup>; and  
4

5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is  
6 essential to optimizing health care access and the quality of patient care; and  
7

8 Whereas, many barriers remain and unique challenges persist for some diverse groups  
9 attempting to enter the medical field and successfully matriculate through the profession of  
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and  
11

12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%  
13 identified as Hispanic, and ~5.0% identified as Black or African American<sup>2</sup>; and  
14

15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in  
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American  
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to  
18 increase by 26% by 2030;<sup>3,4</sup> and  
19

20 Whereas, black people account for roughly 13 percent of the US population, they make up only  
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when  
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These  
23 representational disparities have not changed appreciably in decades;<sup>3,4</sup> and  
24

25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates  
26 of remedial intervention and dismissal from their programs than their White counterparts, thus  
27 leading to concerns of over-policing in medical education; and  
28

29 Whereas, over-policing in education begins as early as primary school and continues through  
30 high school, college, medical education, and into the workforce. In graduate medical  
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in  
32 the residency selection process;<sup>5</sup> and  
33

34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly  
35 20% of those who were dismissed in 2015;<sup>7</sup> and  
36

37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms  
38 of depression and anxiety among minority students, residents and physicians. This often leads

to reducing practice hours or leaving medicine, creating even greater workforce disparities;<sup>5</sup> therefore be it

RESOLVED, that our American Medical Association further study and track the prevalence of attending physicians' and trainees' dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA engage stakeholders to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms (Directive to Take Action); and be it further

RESOLVED, that our AMA work with stakeholders to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings. (Directive to Take Action)

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

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#### RELEVANT AMA POLICY

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

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support

individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16 Modified: Res. 009, A-21 Modified: CME Rep. 5, A-21]

### **Continued Support for Diversity in Medical Education D-295.963**

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03 Appended: CME Rep. 6, A-11 Modified: CME Rep. 3, A-13 Appended: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Appended: Res. 319, A-22 Modified: Res. 319, A-23]

### **Diversity in the Physician Workforce and Access to Care D-200.982**

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. [CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-21]

### **Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. [CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19 Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23]