OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Jeremy A. Lazarus, MD, Chair:

1. PALLIATIVE CARE

CEJA Opinion; No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2024 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-24, "Expanding Access to Palliative Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-5.10 – Palliative Care

Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by illness and injury and to respect their patients as whole persons. These duties require physicians to assure the provision of effective palliative care whenever a patient is experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative care is sound medical treatment that includes the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, spiritual, and existential distress from serious illness. Evaluation and treatment are patient-centered but with an additional focus on the needs, values, beliefs, and culture of patients and those who love and care for them in decision-making accordingly.

Palliative care is widely acknowledged to be appropriate for patients who are close to death, but persons who have chronic, progressive, and/or eventually fatal illnesses often have symptoms and experience suffering early in the disease course. The clinical ethical responsibilities to address symptoms and suffering may therefore sometimes entail a need for palliative care before the terminal phase of disease. Moreover, the duty to respect patients as whole persons should lead physicians to encourage patients with chronic, progressive, and/or eventually fatal conditions to identify surrogate medical decision makers, given the likelihood of a loss of decisional capacity during medical treatment.

When caring for patients' physicians should:

Integrate palliative care into treatment.
Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.

Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.

Be aware of, and where needed, engage palliative care expertise in care.

Physicians as a profession should:

Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness. (I, V, VIII)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Jeremy A. Lazarus, MD, Chair:

1. THE AMA CODE OF MEDICAL ETHICS EVOLVING TO PROVIDE HEALTH CARE SYSTEMS ETHICS GUIDANCE

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-140.818

BACKGROUND

In 1847, the AMA established the world's first national code of ethics for physicians [1-2]. Stewarded by the Council on Ethical and Judicial Affairs (and its predecessors), the AMA *Code of Medical Ethics* is continually updated to help physicians meet their ethical obligations to patients in an ever changing scientific and practice environment [3]. As a living document, the *Code* has gone through major updates. In 1957, a major revision of the *Code* distinguished medical etiquette from medical ethics. In 1980, the *Code* was updated to address the tension between ethical standards and legal requirements [4]. More recently, the *Code* modernization project, completed in 2016, worked to ensure that Ethical Opinions in the *Code* were internally consistent, used modern terminology, and provided sound ethical guidance to physicians [5].

While the *Code* remains focused on the ethical duties of physicians, today's practitioners interact with many health care-related organizations, whether they be hospitals, insurers, or pharmaceutical companies. One major structural change in the practice environment is that most physicians are no longer self-employed (or their own bosses) and are now employees of hospitals, group practices, or other corporate entities. For example, the trend towards employed physicians accelerated within recent years, and the number of physicians in private practices dropped below 50 percent for the first time in 2020 [6]. Consequently, the decisions that physicians make in service to their patients are increasingly shaped, influenced, and sometimes dictated by organizational actors.

ETHICAL ISSUE

When organizational actors shape, influence, or dictate decisions that physicians make in service to their patients, it can create moral tension and ethical conflict between physicians and the health care organizations with whom they are interacting. For the *Code* to serve its purpose in this rapidly changing practice environment, its ethics opinions should speak to how health care organizations can support physicians in meeting their ethical obligations to patients, or what will be referred to as "health system ethics" for the remainder of this report.

Up to now, the *Code* has addressed health system ethics indirectly by speaking to the ethical responsibilities of physicians in organizational leadership positions and a case-by-case basis such as in Opinion 11.2.7, Responsibilities to Promote Equitable Care. Therefore, the issue is whether the *Code* should again evolve so that its opinions also provide ethics guidance to health care organizations regarding how they can support physicians in upholding their ethical obligations to patients.

ETHICAL ANALYSIS

The purpose of the *Code* addressing health systems ethics is to provide guidance regarding actions health care organizations ought to take to create environments that will support and enable physicians to abide by and uphold their individual ethical obligations and duties. As this is a new way of approaching the development of ethics opinions within the *Code*, the Council on Ethical and Judicial Affairs sought feedback from various stakeholders as follows:

- CEJA Open Forum at I-23 entitled "Should the AMA *Code* Speak to Health Care Systems." Invited panelists included Drs. Michael Suk, Jessie Ehrenfeld, and Michael Tutty of our AMA leadership.

- A virtual meeting in October of 2024, with physician leadership from key AMA Sections and Councils. Attendees included Dr. Nancy Church from the Organized Medical Staff Section, Dr. Stephen Parodi from the Integrated Physician Practices Section, and Drs. Betty Chu and Steve Epstein from the Council on Medical Service.
- CEJA Open Forum at I-24 entitled "Evolving the AMA *Code* to Speak to Health Care Organizations." Invited panelists included Dr. Christopher DeRienzo, Chief Physician Executive, at the American Hospital Association and Julie Wagner, Head of Global Ethics, Compliance, and Enforcement Legal Policy, at the Pharmaceutical Research and Manufacturers of America.

During these above engagements, there was broad support expressed for the *Code* to address health system ethics. The ethics logic for moving toward providing health system ethics guidance is premised on the understanding that when health care organizations are acting ethically, physicians are better able to provide high quality patient care. Additionally, when any party to patient care fails to act ethically, patients' trust in the medical profession and of health care organizations can be undermined, contributing to greater moral distress and burnout among physicians, as well as damaged organizational reputation and market position for health care organizations.

RECOMMENDATION

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

That our AMA supports the continued evolution of the *Code of Medical Ethics* in addressing how health care organizations and physicians can work together in meeting their mutual obligations to serve patients and the public.

Fiscal Note: Less than $500

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2. SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE ACTIONS AND/OR UNIONIZATION

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

HOUSE ACTION: REFERRED

Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was adopted at the 2023 Annual Meeting and asks that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of

physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities [1]. Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019 [2]. As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1 percent of practicing physicians [1]. Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

As the financing, organization, and leadership of the health care system change, the practice environment increasingly makes it challenging for physicians to provide the kind of care patients want and deserve. Physicians are now increasingly held to strict performance metrics that many feel are more about meeting corporate financial goals than they are about providing quality patient care. As a recent New York Times article puts it, "longer-term consolidation of health care companies has left workers feeling powerless in big bureaucracies. They say the trend has left them with little room to exercise their professional judgment" [3]. There is a growing sense among physicians that current working conditions are increasingly compromising the patient–physician relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and retirement from medicine.

Unions are seen by some as a mechanism for physicians to exert influence on corporate health systems where physicians have less autonomy than in private practices [4]. Unions' power for collective bargaining comes from their ability to organize members to take collective action. Unionization, however, is not the only means by which physicians can organize and take collective action. Hospitals' organized medical staff has been a means by which physicians have exercised authority over decision making and culture, but the authority and scope of responsibility of the organized medical staff has been limited [5]. While employed physicians in large systems have not explored re-invigorating the organized medial staff, this remains an alternative means by which physicians can reclaim lost authority and exercise collective action.

Physicians may undertake many forms of collective action, both in the public arena and within health care institutions. Public actions include, but are not limited to, public advocacy, media campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting increasingly are being considered as additional forms of collective action, particularly to effect change in specific clinical environments. Some of these are not disruptive, such as negotiation with administrators. Disruptive actions are also being considered, such as picketing, refusal to comply with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A primary concern surrounding the use of these disruptive collective actions by physicians in the clinical setting is that some of these actions may impact patient care and thus be in direct conflict with physicians' professional and ethical duties to not abandon patients and to prioritize patient care above self-interest [6].

Relevant Laws

In 1935, Congress passed the National Labor Relations Act (NLRA), amended in 1947 through the Taft-Hartley Act, which guarantees private sector employees the right to unionize, engage in collective bargaining, and take collective actions such as strikes [1]. The NLRA covers most private sector employees but does not cover independent contractors, supervisors, or managers. Part-time physicians working as independent contractors, physicians in private practice, and physicians considered to serve a supervisory role, such as medical directors or tenured medical faculty, are currently excluded [2].

When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit hospitals, it added Section 8(g), requiring health care employee unions to give at least a ten-day notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to make appropriate arrangements for the continuity of patient care in the event of a work stoppage [2].

Laws prohibiting the corporate practice of medicine are an under-appreciated mechanism for physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s that prohibit the corporate practice of medicine, but little attention has been paid to the potential use of such laws to prevent health care institutions from infringing upon the clinical decision-making authority that properly belongs to physicians [7].

Relevant AMA Policy Provisions

In 2019, the AMA modified two relevant policies: H-385.973 "Collective Negotiations" and H-385.976 "Physician Collective Bargaining" [8,9]. Both support the right of physicians to engage in collective bargaining and express the AMA's commitment to work for the expansion of which physicians are eligible for that right under federal law. This includes supporting efforts to narrow the definition of supervisors such that more physicians are protected under the NLRA.
Though not policy, the AMA's Advocacy Resource Center has also issued a recent Issue Brief: "Collective bargaining for physicians and physicians in training" that outlines AMA policy on physician unions and collective bargaining, including the interpretation that the AMA's position is that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care" [2].

Relevant Code *Provisions*

The AMA *Code of Medical Ethics* Opinion 1.1.1, "Patient-Physician Relationships," states that the core tenets of the clinical encounter for the physician are "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the primary ethical duties of physicians to prioritize patient care and regard their responsibility to the patient as paramount. The Principles enumerated in the Code also indicate that such duties extend beyond the bedside and that physicians have a responsibility to seek changes to laws that are contrary to the best interests of the patient.

Opinion 1.2.10, "Political Action by Physicians," currently states that not only *can* physicians seek to change policies or laws that they find contrary to the best interest of patients but they in fact *have* an ethical duty to do so, though they also "have a responsibility to do so in ways that are not disruptive to patient care" [10]. While the opinion states that "[s]trikes and other collective actions […] should not be used as a bargaining tactic", it also adds that "[i]n rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care" [10]. However, this permissibility must be balanced by the opinion's first directive that physicians participating in advocacy activities should "[e]nsure that the health of patients is not jeopardized and that patient care is not compromised" [10].

This is in line with Opinion 1.1.6, "Quality," which states that "[a]s professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable" [11]. Taken together, by stating that "physicians have an ethical responsibility to seek change" at times (Opinion 1.2.10) and that they also have an "obligation to ensure" quality care (Opinion 1.1.6), these opinions highlight the fact that certain conditions may arise that actually demand action be taken by physicians to improve patient care.

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised [12]. The opinion stipulates that physicians have a responsibility both individually and collectively to ensure and promote health and wellness among physicians, and that when their health or wellness is compromised, individual physicians should fulfill this responsibility by "taking measures to mitigate the problem" [12]. Physician health and wellness is necessary for effective healing and the provision of quality care, and collective action may be an appropriate means of securing institutional conditions that are conducive to patient health and well-being.

Additional Relevant Policy

The World Medical Association recommends that physicians adopt the following guidelines regarding collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.

3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care [13].

ETHICAL ISSUE

What are the ethical considerations regarding participation in collective labor action by physicians? Since certain collective actions can be disruptive, they present a potential risk to patient care and thus create a dilemma for physicians, particularly when collective actions may create immediate risks to patients, even if intended as a means to improve patient care in the long term. What collective actions by physicians are ethically permissible must be examined to ensure that the primacy and quality of patient care are protected. The core ethical issue is whether physicians who embrace tactics used by organized labor will also still be able to embrace their role as professionals.

RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

While not all collective actions by physicians may impact clinical practice, disruptive actions such as strikes result in practical challenges to clinical care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Some of these actions may have the potential to decrease quality of care and cause patient harm.

REVIEW OF RELEVANT LITERATURE

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable [6,13,18,19,20]. However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income [6,18].

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognizes physicians as laborers with all the rights of laborers, while drawing limits that protect the public from harm.

A second line of argument is a variation on this first line of argument—asserting that while medicine is ideally construed as a profession with intrinsically special rights and obligations, one must now, however reluctantly, accept the de-professionalization of physicians as a socioeconomic and historical fact. On this view, physicians have been forced out of their professional status by changes in the financing and organization of health care and the only available means of asserting power now is through unionization and the means of negotiation that have been used for the last two centuries by other workers in resolving disputes with their employers. Again, the operative ethical question becomes one of setting limits on these actions in accord with the vital nature of the service physicians provide.

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large health care systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if

impediments to good patient care are sufficiently serious, and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short-run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified [6,19]. These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed, and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived, or, at least, difficult for the public to believe [6,19,21].

Others have held that strikes by physicians are almost never justifiable [22-24]. Strikes by physicians raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

Whatever justification they may have, strikes or "slow downs" by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the medical profession has thus been compromised by physicians themselves. Those who choose to pursue self-interest, as union members may, cannot at the same time demand a superior moral position in society [22].

Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle that the duty to promote the good of the patient is always paramount, and that strikes will always harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to disrupt care, inconvenience, or possibly harm patients, even if minimally, in order to pressure administrators into acceding to the demands of the striking physicians. Even granting that the ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the short run, and this conflicts with the profession's ancient duty to protect patients from harm.

Moreover, opponents take issue with the consequentialist argument that some patients could justifiably be exposed to potential harms now for the sure benefit of others in the future. They argue that a primary principle of ethics is that persons should always be treated as ends in themselves and never as means only. Physician strikes, by their nature, instrumentalize some patients, using their potential harm as means of achieving physicians' ends, even if those ends are justifiable and good.

Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the glue that holds the patient-physician relationship together. The sense that one's own health as a patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in the profession.

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care [25-28], much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability [26,27]. Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes [25]. Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain [28]. This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution [29].

ETHICAL ANALYSIS

In its review of Opinion 1.2.10, "Political Action by Physicians," CEJA has examined the ethics of collective actions by physicians. While the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical dilemma is whether physicians can, in fact, fully understand themselves as professionals called to prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit.

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the health care sector has seen an increase in the complexity of health care systems, the transition to a majority physician employment structure, and as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other non-physicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

The result is a general loss of control over practice conditions that have driven dissatisfaction, burnout, and early retirement from the profession. However, the issue is not necessarily employment itself, but the associated loss of independence of clinical practice and control over the clinical environment, which many today see as the de-professionalization of medicine.

For those seeking to maintain and restore physician authority and independence, the primary avenue has been to pursue legal and political actions, such as lobbying (either independently or through specialty associations). However, with the change towards physician employment, physicians are now considering the use of tools that laborers have historically relied on for negotiating, such as legally permissible collective actions, in their attempts to improve patient care. This acceptance of the tools of organized labor, however, is in tension with medicine's self-understanding and public representation of itself as a profession with distinct privileges granted by society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are not likely to violate the norms of medical professionalism [30]. Disruptive collective actions, however, which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the medical profession's fundamental duty to do no harm and care for patients. Any disruptive collective action that causes harm to patients is inherently inconsistent with the responsibilities and duties of physicians.

Disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are therefore to be avoided. This does not mean, however, that all forms of disruptive collective action must be avoided. Certain forms of disruptive action, such as collective refusal to comply with administrative directives that are understood as antithetical to good patient care or otherwise incompatible with the norms of professional ethics, may be ethically justified. Other forms of disruptive action that are aimed at disrupting administrative processes such as billing but do not disrupt service to patients, might also be justified. Disruptive actions should only be undertaken, however, as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted. Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

Physicians thinking about participating in disruptive collective actions therefore must first consider their professional responsibilities and obligations.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed:

That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:

Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy.

Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.

When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions:

~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing.

~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.

Physicians should refrain from collective action that could jeopardize the health of patients or compromise patient care.

Physicians may consider engaging in disruptive forms of collective action that do not compromise patient care only as a last resort, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

Disruptive actions, including strikes, that could directly compromise patient care should be avoided and should not be used solely for physician self-interest.

Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients.

Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities.

That Policy H-405.946(2) be rescinded as having been accomplished by this report.

Fiscal Note: Less than $500

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3. RECONSIDERING TERMINOLOGY TO DESCRIBE PHYSICIAN ASSISTED SUICIDE

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

At the 2023 Interim meeting, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

BACKGROUND

The AMA *Code of Medical Ethics* defines physician assisted suicide (PAS) (Opinion 5.7 "Physician-Assisted Suicide") as the practice of a physician facilitating "a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act". In companion 1997 cases, the US Supreme Court held that there is no Constitutional right to PAS, and, therefore, permissibility should rest with the states [1]. Over the nearly three decades since, 10 states and the District of Columbia have legalized the practice [2].

ETHICAL ISSUE

Resolution 004 directed the Council on Ethical and Judicial Affairs (CEJA) to study whether current research, practice, or policy changes warrant reconsideration of CEJA's ethical analysis and/or position on PAS.

ETHICAL ANALYSIS

At the 2019 Annual meeting, the AMA House of Delegates adopted CEJA Report 02-A-19 entitled "Physician-Assisted Suicide" and upheld AMA *Code of Medical Ethics* Opinion 5.7 which opposes PAS as a practice that is "fundamentally incompatible with the physician's role as a healer." CEJA Report 02-A-19 also recognized, in an Appendix, that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide." This Appendix noted that the AMA *Code* preserves the opportunity as articulated in Opinion 1.1.7, "Physician Exercise of Conscience," for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice."

AMA's position on physician assisted suicide is not a position of neutrality, establishing that the profession of medicine should not support the practice of physician assisted suicide or see it as part of a physician's role. The aim of the Appendix to CEJA Report 02-A-19, however, is to reassure individual physicians that those who, after due

moral consideration, decide to participate in the practice, will be judged to have acted conscientiously, consistent with the AMA *Code*.

In developing CEJA Report 02-A-19, the Council's analyses and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the *Code of Medical Ethics*. The Council has reviewed legislative developments since 2019 and has also reviewed recent government data, health services research and clinical practices in US and international jurisdictions where PAS and/or euthanasia are legal. The Council noted that these empirical data are subject to varied interpretations and concluded that, as a matter of ethical reasoning, the data do not settle the ethical issue. The relevant core ethical values at stake have not changed since the adoption of CEJA Report 02-A-19. As such, the AMA's position on physician assisted suicide remains unchanged.

Fiscal Note: Less than $500

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States Where Medical Aid in Dying is Authorized - Compassion & Choices. compassionandchoices.org. Accessed February 27, 2025. https://compassionandchoices.org/states-where-medical-aid-in-dying-is-authorized/.

4. RECONSIDERATION OF PHYSICIAN ASSISTED SUICIDE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2023 Interim meeting of the AMA House of Delegates, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

BACKGROUND

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5. PROTECTING PHYSICIANS WHO ENGAGE IN CONTRACTS TO DELIVER HEALTH CARE SERVICES

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

See Code of Medical Ethics Opinion 11.2.3

Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," asks 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", the Council on Ethical and Judicial Affairs (CEJA) presented Report 02-A-23, Report 03-A-24, and Report 02-I-24, which offered recommendations on amending Opinion 11.2.3, "Contracts to Deliver Health Care Services." The last report was referred back to CEJA at the 2024 Interim Meeting, with testimony expressing a desire that a stronger stance be taken against private equity's (PE) involvement in health care, noting that the report placed too high of a bar on physicians contracting with private equity and needs stronger language to guide physicians working for private equity investors. CEJA acknowledges that private equity investment in health care raises pressing, complex issues, which will ultimately require multiple avenues to address, such as the related Council on Medical Service report (CMS 03-A-25) on private equity and the corporate practice of medicine as well as work currently being done by our AMA's Advocacy unit to promote physician-led care and reduce burnout. The present report has been revised in light of the valuable comments proffered at the last meeting, and offers specific ethics analysis and guidance for physicians impacted by private equity's involvement in medicine.

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 in private practice [3,4]. Our AMA reports that this trend is continuing: "[e]mployed physicians were 50.2 percent of all patient care physicians in 2020, up from 47.4 percent in 2018 and 41.8 percent in 2012. In contrast, self-employed physicians were 44 percent of all patient care physicians in 2020, down from 45.9 percent in 2018 and 53.2 percent 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 percent, with health care deals compromising 18 percent 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 three to seven years and yielding a return of 20-30 percent [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 with promising later-stage ventures, and traditional private equity firms that borrow money through a leveraged buyout to take a controlling stake of mature companies [7]. Private equity firms represent a unique business model within health care due to their primary focus, not on goods or services, but on quick returns on financial investment, emphasis on fulfilling promises to investors, and treatment of health care entities as not substantially different from non-health related investments.

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

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

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

While more empirical research is needed on the impacts of private equity investment in health care, there is a growing accumulation of evidence that private equity investment results in negative outcomes, including increases in costs, decreases in the quality of patient care, and decreases in patient satisfaction [10-13]. This is particularly worrisome as private equity firms are emerging to be major employers of physicians. Currently, it is estimated that 8 percent of all private hospitals in the U.S. and 22 percent of all proprietary for-profit hospitals are owned by private equity firms [14].

Relevant Laws

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

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

To protect patients from harmful billing practices, the federal government has passed the No Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most states have similar laws, such as those barring fee-splitting and self-referral, and several states have passed laws regulating or restricting the use of gag clauses in physician contracts [1]. In 2024, the FTC also issued a final rule banning noncompete clauses in all employment contracts; while a district court issued an order stopping the FTC from enforcing the rule, the FTC has appealed that decision [15].

The federal Emergency Medical Treatment and Labor Act ensures that hospitals with an emergency department provide all patients access to emergency services regardless of their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58 percent of community hospitals, provide some level of charity care as a condition for their tax-exempt status, which the Internal Revenue Service defines as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of the services" [16].

While there is no federal law banning the corporate practice of medicine (CPOM), most states do have CPOM laws that prohibit corporations from owning or operating medical practices. However, these state laws typically include exceptions that allow corporate investors, such as private equity firms, to invest in health care entities through a physician management company or management services organization, and which also provide potential avenues for corporate investors to circumvent stringent limits on their operational authority.

Relevant AMA Policy Provisions

Council on Medical Service Report 11-A-19 reviewed the scope and impact of private equity and venture capital investment in health care, and its recommendations were adopted as Policy H-160.891, "Corporate Investors." This policy delineates 11 factors that physicians should consider before entering into partnership with corporate investors, including alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners.

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

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

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."

Policy H-385.926, "Physician Choice of Practice," states that "[o]ur AMA supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.)." While this policy upholds physician autonomy and supports the freedom of physicians to choose where and how they practice, the right to choose a method of earning a living is not unbounded, as the policy also states that physicians should charge their patients fair fees and provide "adequate fee information prior to the provision of services" whenever possible.

Additionally, policy H-215.981, "Corporate Practice of Medicine," states, "[o]ur AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups." This policy recognizes the attendant risks that the corporate practice of medicine represents to both patients and the practice of medicine.

Relevant AMA *Code Provisions*

Opinion 10.1.1, "Ethical Obligations of Medical Directors," states that physicians in administrative positions must uphold their core professional obligations to patients. The opinion mandates that physicians in their role as medical directors should help develop guidelines and policies that are fair and equitable, and that they should always "[p]ut patient interests over personal interests (financial or other) created by the nonclinical role."

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. While the FTC issued a rule in April 2024 banning most noncompete agreements, a Texas District Judge issued a preliminary injunction on July 3, 2024, halting the enforcement of the ban.

ETHICAL ANALYSIS

The increasing corporatization and financialization of health care have generated legitimate concerns over ethical dilemmas they raise regarding a focus on profits at the expense of patient care. Prioritizing profits over patients is incompatible with physicians' ethical obligations. In other words, because it is unethical for physicians to place profit motives above commitments to patient care and well-being, when private equity firms invest in health care, their business model is prima facie ethically problematic for physicians. Private equity's primary objective of fast profit-making in order to uphold their promises to investors is at odds with physicians' primary obligation of acting in the patient's best interest.

However, although private equity-owned health care entities are different in their ownership structure and oversight compared to other traditional health care investors, private equity-acquired health care entities may not be substantively different from other for-profit and non-profit health care entities 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 comes with ethical and professional risks that are perhaps best exemplified by private equity but are not unique to private equity alone. One only needs to turn to the systemic failure of nonprofit hospitals to provide adequate charity care or how for-profit hospitals often reduce access to care (particularly for Medicaid recipients) to see examples of how the corporatization and financialization of medicine has increasingly come to treat health care as a mere commodity [17,18]. This is despite the fact that health care is inherently different from normal market goods because the demand for health care is substantially inelastic and nonfungible, and medical knowledge is a social good collectively produced by the work of generations of physicians, researchers, and patients. The real problem with private equity's involvement in health care is that it blatantly reveals that as a society, we have increasingly moved towards treating health care as a commodity when as a profession, we know this should not be the case.

While business ethics and medical ethics are not inherently antithetical, differences do clearly exist [19]. Many physicians are thus justly concerned about any removal of professional control that may accompany the increasing

commercialization of the physician's role. Veatch points out that paradoxically, despite being open to the profit motive in the practice of medicine, the profession as a whole has shown strong resistance to the commercialization of medical practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental right or a commodity like any other, adding that the notion of health care as a right jeopardizes any profit motive in health care including traditional private practitioner fee-for-service models [19].

Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human good that society has an obligation to provide in some measure to all citizens [20]. Pellegrino argues that health care is substantively different from traditional market goods—it is not fungible, cannot be proprietary because medical knowledge is possible only due to collective achievements, is realized in part through the patient's own body, and requires an intensely personal relationship—and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine turns any interaction between the patient and physician into a commercial transaction subject to the laws and ethics of business rather than to medical and professional ethics. "In this view," Pellegrino writes, "inequities are unfortunate but not unjust […]. In this view of health care, physicians and patients become commodities too" [20].

As health care has become increasingly commodified, the ethical risks to patients and physicians are being realized as physicians find themselves increasingly working as employees and worrying about the impact commercial enterprises—such as private equity investments—may be having on patients.

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

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

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

While the profit motive of private equity firms may drive them to take part in less than scrupulous practices, such as private equity's exploitation of out-of-network surprise billing, there is also potential for private equity to play a more positive role in transforming health care practices [1,21]. Powers et al write:

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

Private equity firms could help accelerate changes in health care payment and delivery towards value-based models. With such models, where financial performance is tied to quality and value, private equity may be incentivized to invest in changes that support better health and lower costs [21].
While more research is needed on the impacts of private equity investments in health care and on de-investment, when private equity firms ultimately pull out of a health care sector, private equity firms' involvement in health care does not appear to be exceptional within the current corporate transformation of the profession. As Fuse Brown and Hall point out, "PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine. And so long as the U.S. treats health care as a market commodity, profit-seeking will persist" [1]. Any financing model of health care that ignores patient care or puts profits over patient care should be considered unethical by physicians and the public.

Concerns over private equity's incursion into health care are clearly warranted. However, the financial and investment landscape of health care continues to evolve, and while private equity may be the latest trend it will not be the last version that emerges within the health care marketplace. Health care spending in the US continues to rise each year, with health spending increasing by 4.1 percent in 2022 for a total of $4.5 trillion and accounting for roughly 17 percent of total GDP [22]. With so much money involved in health care, it is bound to draw in investors; the involvement of investors from outside of health care, who may treat it as merely a market commodity and do not share physicians' overriding commitment to patient care and well-being, should be concerning. Such involvement by outside investors is likely to further transform health care, driving consolidation, commercialization, and de-professionalization.

In a practical approach to the current financial health care landscape, Ikrum et al offer some realistic recommendations for partnering with private equity in health care:

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

While private equity's overriding profit motive may be unethical in many instances, the reality is that private equity is already a large player in health care and physicians urgently need guidance on how to interact with private equity firms and private equity-owned health care entities. Keeping within its purview, the *Code* should offer guidance to physicians and to the practice of medicine on how to best interact with private equity and other outside forces that increasingly impact health care today. To support physicians as private equity continues to increase its market share of health care entities, practical guidance is needed related to both the sale of physician-owned practices to private equity as well as to those seeking employment by private equity-owned health care entities to help physicians navigate today's evolving financial health care landscape. Guidance is also needed for physicians employed by corporate entities that interact with the health care profession, including by private equity firms, management service organizations (MSOs), professional services corporations (PCs), insurance companies, and pharmaceutical benefit managers (PBMs).

CONCLUSION

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. As highlighted by policy H-215.981, "Corporate Practice of Medicine," it is not some corporate practices but all corporate practices of medicine that create the potential for ethical dilemmas and so should be avoided. Any decision to pursue financial incentives over and above patient care is unethical, and physicians' concerns regarding private equity's focus on short-term profits at the expense of patients' and their own well-being are justly warranted. Due to such concerns, physicians should strongly consider whether they can sell their practice to private equity investors while also upholding their ethical and professional obligations to patients and to the profession as a whole. Such reflection is also warranted for any physician considering employment by a corporate entity, such as a private equity firm, MSO, PC, insurance company, or PBM.

It is therefore crucial that policy guidelines be developed to ensure that private equity-acquired hospitals, hospital systems, and physician practices 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]. The growth of private equity investment within the health care marketplace is clearly concerning and is an urgent issue that needs greater regulatory oversight. Beyond established ethical and professional norms, new regulations must be developed to prevent private equity from negatively impacting patient care and the medical profession [6]. A new Senate Budget Committee Bipartisan Staff Report, released in January 2025, calls for greater oversight, transparency, and restrictions of private equity involvement in health care [23]. While the report acknowledges that "not every PE firm operates in an identical fashion, the evidence highlights systemic issues with PE in investment in health care," and goes on to

conclude, "the findings of the investigation call into question the compatibility of private equity's profit-driven model with the essential role hospitals play in public health. The consequences of this ownership model—reduced services, compromised patient care, and even complete hospital closures—potentially pose a threat to the nation's health care infrastructure, particularly in underserved and rural areas" [23].

Because the private equity business model creates serious potential risks and conflicts of interest for the practice of medicine, it is essential for physicians considering entering into partnership with private equity firms to first reflect on their ethical and professional obligations. If they do decide to proceed, however, physicians have a duty 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—whether with a private equity-owned hospital or otherwise—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]. While we must acknowledge that physicians often have little power in contract negotiations, their ethical obligation remains nonetheless to try to negotiate when contractual agreements are likely to lead to ethical dilemmas. If a contract would prevent a physician from upholding their professional ethical obligations, the contract should not be entered into.

The Preamble to the *Code* stipulates that "[o]pinions of the AMA Council on Ethical and Judicial Affairs lay out the ethical responsibilities of physicians as members of the profession of medicine." Although some areas of concern therefore extend beyond what the *Code* may speak to, CEJA is currently studying the ethical obligations of health care entities that interact with physicians and is considering entering a report in the near future regarding the potential need for a new opinion to address additional stakeholders involved in our evolving health care landscape. CEJA recognizes that private equity investment raises concerns for physicians and for the practice of medicine but also acknowledges the *Code* is unable to speak to the totality of the issues raised by such investment practices. This is why it is crucial that multiple AMA units, such as the Council on Medical Service's related report on private equity, work in tandem to address the complexity of the many issues raised by private equity firms' investment in health care entities.

It is the conclusion of the Council on Ethical and Judicial Affairs that increasing investment by private equity firms in health care raises ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services," to more clearly address concerns raised by entering into partnerships with private equity firms, physicians employed by corporate entities (including private equity firms, MSOs, insurance companies, and PBMs), and the ethical risks that may arise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned health care entities.

RECOMMENDATION

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:

Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. 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. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

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
arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:
Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:

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

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

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

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

(v) is transparent and permits disclosure to patients~~.~~;

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

(vii) prohibits the corporate practice of medicine.

Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

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

Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:

Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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6. AMENDMENT TO OPINION 1.1.1 "PATIENT-PHYSICIAN RELATIONSHIPS"

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

HOUSE ACTION: REFERRED

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be better served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians' associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole.

BACKGROUND

Relevant House Policies

Several House policies reference the importance of the patient-physician relationship. Though not an exhaustive list, the following policies capture the spirit of the patient-physician relationship expressed within AMA House policy: H-165.837 "Protecting the Patient-Physician Relationship", H-225.950 "AMA Principles for Physician Employment", and H-275.937 "Patient/Physician Relationship and Medical Licensing Boards" [1-3]. The patient-physician relationship as expressed by these policies is understood to be fundamental and paramount to the practice of medicine. This relationship is understood to carry certain obligations for physicians, including the duty to be patient advocates, to prioritize patient care, and be transparent regarding cost-sharing arrangements. Other considerations, including personal financial concerns, are to be secondary to the relationship. Furthermore, this relationship is not perceived as purely contractual, as termination of employment does not necessarily end the relationship between a physician and persons under their care (H-225.950).

Relevant Code Provisions

Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as: "fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering[… that is] based on trust" (Opinion 1.1.1). This relationship is primarily represented as emerging from a physician's fiduciary duty to patients, in which both parties enter into this fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following opinions capture the spirit of the patient-physician relationship expressed within the *Code:* Opinion 1.1.1 "Patient-Physician Relationships", Opinion 1.1.3 "Patient Rights", Opinion 1.1.5 "Terminating a Patient-Physician Relationship", Opinion 1.1.6 "Quality", Opinion 1.1.7 "Physician Exercise of Conscience", Opinion 8.6 "Promoting Patient Safety" [4-9]. These opinions demonstrate that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for the continuity of care, open communication, quality care, and trust.

ETHICAL ISSUES

Current guidance in Opinion 1.1.1 "Patient-Physician Relationships" focuses heavily on legal considerations about when a relationship is established and has little purchase on the ethical concerns raised by extensive changes to the practice of medicine that have recently occurred. Among these changes are the continuing development of technology (such as augmented intelligence), the use of team-based care, the rising number of employed physicians (as contrasted with those in private practice), interference in the patient-physician relationship by third parties (such as health care administrators, insurers or government), and the recognition that physicians have an obligation to advocate for changes to institutions, policies, and practices in order to improve patient care and promote health care justice.

A major change to the patient-physician relationship over the past few decades has been an increased recognition of the importance of patient autonomy. Ironically, however, this move away from paternalism towards patient autonomy in the setting of the patient-physician relationship has taken place while medicine has come to be dominated by large institutions, financial concerns such as cost-containment, changes in financing designed to influence patient and physician behavior, commercialization, an increasing reliance on markets, and other pressures that have had a de-professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for both physicians and patients. Even as the discretionary space of physicians has shrunk, their responsibilities have expanded. Physicians

are now called to engage in cultural competency and humility, trauma-informed approaches to care, and to recognize past harms and historical contexts of patient populations. They are called upon to be the mechanism by which medical inflation will be controlled. They are called upon to advocate not just only for their own individual patients within systems of care but to advocate for changes in the social systems that determine health care needs and distribute illness, injury, and disability unjustly.

Recognizing that each patient brings different experiences to the relationship is now seen as a crucial part of establishing trust within a patient-physician relationship. The question that arises, however, is how is that trust to be earned within systems that often appear untrustworthy and designed to frustrate the commitment of physicians to act for the good of their patients?

ETHICAL ANALYSIS

The patient-physician relationship is foundational for medical ethics. It is characterized by the nature of illness, the need for healing, and a commitment to help, culminating in a decision to take action directed toward healing and the alleviation of suffering caused by disease, injury, or disability. This relationship is inherently unequal. The patient is unavoidably in a position of vulnerability and dependency, while the physician holds the knowledge and the resources that the patient needs [10]. The sick, injured, and disabled therefore have little choice but to trust that their physicians will use the power of medicine for their good as individual patients. That trust is established by the physician's act of profession—the commitment, generally undertaken through an oath, to be worthy of patients' trust—and the patent's agreement to cooperative collaboration.

The heart of professionalism is thus the public commitment of physicians to use their medical knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first and foremost persons, true healing can only take place when the uniqueness and personhood of patients are taken into account, incorporating their biological particularities, beliefs, relationships, emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek care and be as candid as possible with their physicians.

All medical actions are oriented towards the ethical centrality of the patient-physician relationship. While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the relief of medical suffering and provides healing in a holistic sense even when cure is not possible. Prevention is also oriented towards the good of individual patients and requires trust that interventions are appropriate for that aim. Public health efforts provide the common resources necessary to promote healing and prevent illness, injury, and disability, and thus unite societal commitments to justice and prevention of harm with physicians' duties of beneficence, nonmaleficence, and respect for persons.

This understanding of the patient-physician relationship makes medicine an inherently moral enterprise, qualitatively different from the commercial transactions of providers and consumers. The patient-physician relationship itself is part of the healing process and not a commodity or product. Even economists recognize that the demand for health care is substantially inelastic and nonfungible, placing it outside the assumptions of normative market economics. Medical knowledge is not property that physicians own. It is a social good built up by the work of generations of physicians, scientists, and researchers and made possible by the generosity of generations of patients who have contributed to the advancement of medical progress (and who, it is acknowledged, have not always consented to such participation).
Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political circumstances always condition the patient-physician relationship. Physicians, for instance, do not always live up to the ideals of the profession. Structural social inequities result in unequal access to health care. While the patient-physician relationship itself is not a market commodity, markets provide many of the goods and services that physicians rely on to care for patients. Unfortunately, this also means that these goods and services are subject to the vicissitudes and inequities inherent to market systems, sexism, racism, and other unjust forms of discrimination.

Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the distribution of physicians, the services they can provide for patients, the conditions under which physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the patient is the central moral focus of medicine, a commitment to justice will be required to ensure the integrity of the patient-physician relationship and to make the services of physicians available to all who stand in need of their care. In a pluralistic, liberal democracy, this requires,

in turn, that professions be granted a relatively independent status outside other social institutions such as the market and the government. Too much encroachment by the market or the government into the legitimate authority of the medical profession ultimately undermines the central moral focus of medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation and respect for other social institutions, the medical profession itself can lose track of its own moral center. The good of the patient ought never to be made subservient to the political or financial ends of physicians, governments, or markets. Determining what the good of the patient is requires that physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows for patients to feel heard and respected.

As the profession of medicine continues to change, there are concerns about how these changes impact patient-physician relationships and thus the relevance of the patient-physician relationship itself. However, despite the evolving landscape of the medical profession, the patient-physician relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes to their roles that physicians face, clinical encounters will always be subject to the professional and ethical obligations that emerge from patient-physician relationships.

When we examine the patient-physician relationship, what we are really after is the source of the obligations that ground medical ethics. While medicine has always been practiced under non-ideal circumstances that can make it difficult to carry out these obligations to a maximal extent, we recognize that current circumstances are making it more difficult than ever. Moreover, we recognize that a patient-physician relationship may arise in a variety of contexts, and that these may not always be geared towards benefiting the patient, the physician, or both. The goal of this report, however, is to outline the core aspects of ethical and just patient-physician relationships and articulate gaps in the current *Code* Opinion 1.1.1. in order to better support patients and physicians as the medical profession and health care ecosystems continue to evolve.

Trust and the Patient-Physician Relationship

The pressures of increasing de-professionalization and de-personalization in the healthcare environment have sometimes obscured or even seemed to denigrate the value of the patient-physician relationship. New ethical questions have arisen as systems of care have changed in ways that have made it more difficult for physicians to fulfil their duties that arise from a recognition that this relationship is central to the meaning and value of the profession. While the patient-physician relationship has responded and evolved in light of these challenges and in the face of other technological, economic, and sociocultural changes, there can be no doubt that patients' trust in medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the patient-physician relationship and new attempts to build the trust that sustains it.

Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who study trust have noted that the development of dyadic trust is a process that involves commitment, cooperation, and the building of confidence in benevolent values, motives, goals, and intentions [11]. Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal trust is also impacted by (and in turn impacts) social trust, as social trust influences the development of interpersonal trust which then also impacts trust in the institutions in which interpersonal interactions take place [12].

To protect the patient-physician relationship, then, a central goal of the medical profession should be to foster trust in health care, which has been in sharp decline for the past half century [13]. One of the primary means to engender trust is through good communication. Research has shown that aspects of physician communication can impact patient outcomes (such as medication compliance) and patient satisfaction (which is associated with greater continuity of care), and that patient-centered approaches to care, which consider the patient's perspective on equal ground with the physician's clinical diagnosis, enhance communication and the patient-physician relationship [14].

Fostering Trust to Support the Patient-Physician Relationship

Research on physician communication practices have found at least five broad communication categories including: information giving, information seeking (questioning), partnership building, rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional content), and socioemotional behaviors [15]. How patients and physicians view these aspects of communication, and the patient-physician relationship in general, are not always the same, however. In one study comparing physician and patient evaluations of the relationship, researchers found that while physicians identified their technical expertise and knowledge as vital for establishing trust in the

relationship, emphasizing the importance of competence, devotion, serviceability, and reliability, patients stressed the importance of interpersonal skills as more important, such as caring, appreciation, and empathy [16]. Recognizing this difference in perceptions is crucial for understanding how trust can be gained or lost, especially considering that researchers found trust to make the largest contribution to patient-physician perceived satisfaction [16].

Patient satisfaction is strongly associated with positive physician communication behaviors. Because physicians' communication behaviors vary widely, however, there is significant room here for improving patient-physician relationships. One study found that only 33% of physicians were rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair" or "poor" on all four behaviors [17]. Patient-physician communication is one of the strongest factors that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust [18].

Communication is not the only value that engenders and supports trust. Research has found that clinicians whose patients expressed trust in them worked in environments that placed an emphasis on quality, communication, clinical cohesion, and alignment of values between clinicians and organizational leaders [19]. Like communication, physician empathy has also been regarded as central to patient-centered care, and research has found that empathy correlates with patient satisfaction, adherence, outcomes, and enablement [20]. Other models of trust establish foundational factors that include competency, motive, and transparency [21].

The Future of Patient-Physician Relationships

When considering the source of the ideal patient-physician relationship, its emergence is simultaneously contractual, dependent on virtues, and relational. All three of these conceptual models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency, transparency, aligned motives, and continuity. These values in many ways become ideal virtues within health care that help create trust in the institution of medicine over time, which is crucial for initial clinical encounters as well as for individuals who lack capacity.

Physicians have an ethical duty to support the patient-physician relationship by upholding the virtues of the profession. This ethical duty is grounded in medical professionalism and the commitment to serve as healers. The relationship that patients and physicians enter into is sustained by trust—in both the profession as whole, as well as in both the patient and the physician who agree to participate in a cooperative and collaborative partnership. This trust gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest. This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in importance with respect to both individuals' contributions to the relationship; similarly, the relationship is not a commodity product, yet it involves interacting with market economics. The patient-physician relationship is contextual—biological, historical, socioeconomic, and political elements will always be relevant—but it is also fundamentally a moral activity.

Honavar writes, "[the p]atient–physician relationship is a complex psychosocial interplay of vulnerability, trust, and authority in a professional setting" [22]. Currently, the *Code* primarily speaks to the importance of trust within the patient-physician relationship without acknowledging that the reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power dynamics of every patient-physician relationship will be different, of course, but it is crucial that the *Code* address such concepts as patient vulnerability, the importance of respect, communication, and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve.

RECOMMENDATION

Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed.

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust, which gives rise to~~ The relationship that emerges

between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibility~~y~~ies to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient's medical needs. ~~Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:~~ This generally occurs in response to a request by a patient or a patient's surrogate, but can also occur in certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.

~~When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.~~
~~When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~

~~When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.~~

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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7. GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

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

HOUSE ACTION: REFERRED

Policy D-140.950, "Guidelines on Chaperones for Sensitive Exams," was adopted at the 2022 Interim Meeting and reads as follows:

Our American Medical Association will ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in Code of Medical Ethics," to ensure that it is most in line with the current best practices for adult and pediatric populations and potentially considers the following topics:

Opt-out chaperones for breast, genital, and rectal exams.
Documentation surrounding the use or not-use of chaperones.
Use of chaperones for patients without capacity.
Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
Use of chaperone at physician request when physician deems necessary.

This report is being submitted in response to this directive from the House of Delegates.

BACKGROUND

Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the boundaries appropriate to the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, including their cultural background and beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure [1]. Efforts to provide a comfortable and considerate atmosphere for the patient during sensitive exams are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include the use of chaperones regardless of the gender of the physician or patient [2].

A chaperone "is a trained person who acts as support and witness for a patient exam or procedure" [1]. If the chaperone is trained to do so, they may also assist the provider with equipment and specimen handling. The use of chaperones is appropriate in a variety of specialties and clinical settings [3]. Several states have implemented legal mandates ranging in stringency from requiring that physicians offer a chaperone for sensitive examinations, to "defining examination of the genitals or breasts by a physician of the opposite gender without a chaperone as professional misconduct" [4]. Physicians should therefore make themselves aware of local regulations when they consider their chaperone policy.

Having chaperones present can help prevent misunderstandings between the patient and physician and can protect the integrity of the patient-physician relationship. A fair and effective policy on the use of chaperones must balance: (1) concern for physician and patient safety; (2) respect for patient preferences; and (3) the ethical responsibility to maintain clear professional boundaries.

ETHICAL ANALYSIS

Appropriate use of chaperones during sensitive examinations and procedures is meant to protect both the physician and the patient. Having a chaperone present can increase trust between the physician and patient, contribute to the comfort and safety of the patient, and maintain the patient's dignity. The use of chaperones can also help protect the physician against accusations of misconduct that arise from misunderstandings or that are intentionally false.

There is a power imbalance embedded in the patient-physician relationship. Patients make themselves vulnerable to the physician both by permitting procedures and examinations to be conducted on their bodies and by disclosing private information to the physician during the course of the clinical encounter.

The physician guides the care that the patient receives and should adopt practices within the clinical encounter to foster trustworthiness. The presence of a trained chaperone contributes to establishing the formal nature of the contact between physician and patient, and a chaperone may serve as a witness when a patient expresses concern, asks questions, or withdraws consent. Knowing that the encounter has been witnessed allows both the physician and patient reassurance that the encounter was professional and safe, which fosters trustworthiness.

What is considered a sensitive examination or procedure can vary widely among patients. In order to foster trust between the patient and physician and to set appropriate professional boundaries for sensitive examinations and procedures, various factors affecting the particular patient should be considered, including history of trauma, sexual orientation, gender identity, personal beliefs, and cultural norms and expectations.

Since patients may not disclose their history of sexual assault or previous negative healthcare experiences, trauma-informed care (sometimes alternatively described as "healing centered engagement") [5] should be employed for all examinations, including those not usually understood as sensitive. A trauma-informed framework "assumes that all people have experienced trauma, are experiencing it, or may experience it in the future" [6]. This approach is focused on creating "safety, empowerment and trustworthiness" in the clinical encounter [7]. For sexual and gender minority patients, their lived experiences, perspectives and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive [7]. Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient's level of

comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for *all* patients is to be open to broadening the range of circumstances in which a chaperone is used.

The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate behavior [1]. Patients may be more comfortable with someone of a particular gender being present because that person can better understand the kinds of embarrassment or discomfort associated with their sensitive exam and so may be better equipped to provide support [8].

Patients' right to dignity (Opinion 1.1.3 "Patient Rights") is closely tied to their physical privacy (Opinion 3.1.1 "Privacy in Health Care"). Since medical examinations and procedures often require the patient to put aside their norms regarding modesty and give consent to being seen and touched in ways they would not usually allow, maintaining their physical privacy is a critical way to show respect and foster trustworthiness. The presence of a chaperone reinforces the professional nature of the interaction with the goal of providing reassurance that the patient's experience and wishes are taken into account [1].

Having chaperones present can also help prevent misunderstandings between patients and physicians by clarifying expectations and facilitating communication about the examination. Chaperones who are familiar with the elements of sensitive examinations and procedures, know how to properly observe them, and know when to intervene if they have concerns. Chaperones may augment a patient's sense of safety by ensuring for the patient that the interventions are necessary. Further, having a third-party present who can attest to what occurred during the encounter may protect physicians from false allegations of misconduct [1].

Mandatory, Opt-in, and Opt-Out Chaperone Policies

There are three types of chaperone policy: opt-in, opt-out, and mandatory.

A mandatory policy is one in which a chaperone *must be* present during all sensitive examinations or procedures, or else the examination or procedure will not be performed (except in an emergency).
An opt-in policy is one in which patients are *automatically offered* a chaperone for sensitive examinations and procedures and in other situations one is made available upon request.
An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive examinations and procedures (with an option for the patient to decline with physician agreement), and one is made available upon request in other situations.

Currently, the AMA *Code of Medical Ethics* recommends an opt in policy, meaning that physicians should "adopt a policy that patients are free to request a chaperone and communicate that policy to patients" and that a patient's request should always be honored (Opinion 1.2.4 "Use of Chaperones"). Under the opt-in model, the default is to proceed with the examination or procedure unless an explicit request for a chaperone is made by the patient. This opt-in approach provides less protection for both the patient and physician than a mandatory or opt-out approach, since the responsibility to ask for the chaperone belongs to the patient. The difficulty with this type of policy is that it assumes the patient feels empowered to ask for a chaperone without fear of damaging the patient-physician relationship or causing inconvenience or annoyance [3]. Additionally, evidence suggests that patients may not request a chaperone because they think it may insinuate that their physician is untrustworthy [10,11] and only a small percentage of patients feel comfortable asking for a chaperone when none was explicitly offered [12].

By contrast, under an opt-out policy, patients do not need to make a specific request because the policy makes it standard practice to have chaperones present for sensitive examinations. Specifically, chaperones are made available and routinely present during sensitive exams, unless the patient refuses. Opt-out policies are effective at protecting both the physician and the patient since, by default, they make it the norm to have a third-party present as a witness to sensitive exams or procedures.

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice. Further, if a patient does not speak up (either way), their silence may be taken to be tacit approval, when in actuality the patient is intimidated or does not understand what is happening [13]. Under ordinary circumstances, remaining silent should not be understood as valid consent. While obtaining explicit consent is

important, as noted above, the value of adhering to patient preferences must be balanced against the values of protecting patients and physicians and the maintenance of professional boundaries. These considerations may be weighed differently depending on the specific features of the encounter.

Both opt-in and opt-out policies can create challenges in part because patients' requests and/or consent for use of a chaperone take place directly in the treatment room. For this reason, it has been suggested that patients' preferences regarding chaperones should be solicited by front desk staff or other intake staff as a routine part of the check-in procedure [11,4]. This is an opportunity to provide materials explaining the purpose of the chaperone and to inform patients of the standard policy while allowing patients to express their preferences in a low-pressure environment. However, regardless of where and how consent for the use of a chaperone is solicited and obtained, physicians should keep in mind that what is most important during "the process of obtaining informed consent is equalizing the patient's ability to say *yes* or *no*" [6].

While opt-in policies have historically been regarded as adequate, this is no longer the case in some specialties. There is precedent to believe that a shift to opt-out policies will better protect both patients and physicians in many settings. The American College of Obstetricians and Gynecologists (ACOG) argues that given "the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone" regular use of chaperones is necessary to assure patients and the public that significant "efforts are being made to create a safe environment for all patients" [1]. Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Physicians also deserve to work in an environment where false allegations of misconduct or misunderstandings between physicians and patients do not compromise either their professional reputation or the relationships of trust that they have established with their patients. Likewise, patients deserve to be treated in an environment that supports their agency and improves the quality of their experience, without being expected to make a special request. These goals are best promoted through the implementation of an opt-out policy for the use of chaperones. Therefore, the presence of chaperones should be standard during sensitive exams and procedures. In other situations, it is recommended that chaperones be made available for any examination requiring the patient to disrobe, or when the patient requests one. As such, patients must be informed that they are entitled to request a chaperone whenever they wish. Finally, physicians should honor all patients' preferences for a chaperone even when a trusted companion is present.

Use of Chaperone at Physician Request

There may be times when the physician would prefer to use a chaperone, but the patient declines. In these cases, ACOG suggests:

> "[It] should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible" [1].

Ideally, these conversations will be a process of joint decision-making between the patient and the physician. If the patient declines a chaperone when the physician determines having a chaperone present is clinically indicated, every effort should be made to accommodate the preferences of the patient, consistent with the requirements of patient safety, physician safety, and the maintenance of professional boundaries. Physicians should inquire about specific concerns the patient may have and suggest ways these might be addressed in a mutually acceptable manner. Physicians should engage the patient in a detailed discussion of how care might be provided in a way that maintains a comfortable and respectful environment before deciding that they cannot perform the exam or procedure. Ultimately, "if an unchaperoned examination is performed, the rationale for proceeding should be documented" [1]. As a last resort, if the patient and physician cannot come to an agreement, then the physician may defer the examination or procedure and refer the patient to another clinician. In this situation, patients should be provided with "reasonable assistance in making alternative arrangements" so they can receive care in a timely fashion (Opinion 1.1.3 "Patient Rights").

Use of Chaperone without Patient Consent in Exceptional Circumstances

In many situations, insisting on a chaperone when the patient declines may be a violation of their autonomy and therefore impermissible. However, in keeping with their best clinical and ethical judgment, physicians may nonetheless proceed with a chaperone in the following circumstances:

When it is an emergency and failure to proceed rapidly would result in an immediate risk to the patient's life or long-term health, or
In cases where the integrity of the patient-physician relationship is at risk, such as when a patient's behavior compromises (or has previously threatened) professional boundaries, or the physician has reason to believe such a boundary violation or other unsafe situation is likely to occur. [14]

Documentation of Patient Preference and Chaperone Use

Regardless of the chaperone policy normally implemented in a particular setting, the medical record should reflect the presence or absence of a chaperone for each examination [1,3,11]. The record should include whether the patient requested a chaperone explicitly or one was present as a matter of policy. Additionally, the record should state whether the patient received counseling on the purpose and importance of chaperones, and the name and gender of the chaperone. Note that there are range of acceptable practices for recording chaperone information; the extent of documentation, including what precise data to include, varies among medical specialties. Additionally, with regard to patients' preference for specific characteristics of a chaperone physicians should be mindful not to accede to discriminatory or disruptive patient demands. Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship while also creating an "environment that strains relationships among patients, physicians, and the health care team." (Opinion 1.1.2 " Discrimination & Disruptive Behavior by Patients") Discriminatory requests should not normally be accommodated, and accommodation should only occur after careful weighing of the circumstances.
Pediatric & Adolescent Patients

Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from adult patients because they have different needs and sensitivities. Normally, a parent or guardian may act as the chaperone for young pediatric patients (from newborns to age 11) [15]. In cases where a parent or guardian is unavailable or their presence would interfere with the examination (such as in cases of suspected abuse), another chaperone should be present [15]. Should a parent or guardian decline the physician's request that a chaperone be present in such situations, it may nevertheless be appropriate for the physician to insist for the sake of patient safety.

Addressing the needs of adolescent patients (age 12-17) is more complex. Since many adolescents are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for increased privacy," any examination that requires them to remove their clothes could be distressing [12]. Physicians should not assume that their own definitions of a sensitive examination reflect the understanding of the individual teenage patient [16]. Research shows that 60-70 percent of female adolescents would like the option of a chaperone both for standard and for sensitive examinations. Only 21 percent indicated that they would ask for a chaperone if one was not offered, and substantially more female adolescents wanted a chaperone for sensitive examinations if they had a chaperone in the past [12].

Many adolescents want their parent to act as chaperone instead of a healthcare professional, although in general as their age increases their preference for a non-parent chaperone also increases [16]. Some adolescents did not wish to have chaperones, indicating that it would be more embarrassing, awkward, or uncomfortable to have an additional person in the room [11].

As such, when treating adolescents, the best policy is to explain the role of chaperone in detail and then solicit their preferences. It is also important to ask whether they wish to have their family member or guardian in the room, either in addition to, or instead of, the healthcare professional acting as chaperone. Since adolescents may not have prior experience with chaperones, it is probably not sufficient to have them fill out a form at intake. Instead, their options should be presented during a conversation (and their parent or guardian, if they wish to have them present) so a decision can be made together. Their preferences are also likely to change over time, so this conversation will need to be revisited.

As noted in Opinion 2.2.1 "Pediatric Decision Making," the "more mature a minor patient is […] the stronger the ethical obligation to seek minor patients' assent." This obligation extends to their assent for the presence of a chaperone, as well as their preferences for who the chaperone will be and the gender of the chaperone. In general, physicians and parents/guardians should respect a minor's refusal to assent to a chaperone (except under the conditions mentioned above when a physician may either insist or may decline to proceed with the examination).

Policies around the use of chaperones for adolescents are separate from issues of parental consent for treatment. Physicians should be aware that in some jurisdictions, "the law permits minors to receive confidential services relating to contraception, or to pregnancy testing, prenatal care and delivery services" or to prevent, diagnose, or treat sexually transmitted disease without parental consent and/or notification (Opinion 2.2.2 "Confidential Healthcare for Minors"). Once the legally required consent has been obtained, the minor patient's preferences concerning use of chaperones can be discussed [17].

Patients with Diminished or Lacking Decisional Capacity

It is widely agreed that patients who are unable to give informed consent should always have a chaperone present for sensitive examinations and procedures. These patients might be unconscious, sedated, or have cognitive impairments or severe mental illness [9,2,3]. When treating adult patients who lack capacity to consent, it is desirable to have a trusted companion, social worker, caregiver, or group home escort present alongside the chaperone, "to alleviate potential stress to the patient" [3]. It should be made clear that chaperones are mandatory in these circumstances.

Identifying & Informing Appropriate Chaperones

An authorized member of the health care team should serve as a chaperone and understand the responsibilities of the role. Broadly speaking, chaperones should be provided with information regarding:

Expected components of the procedures they will be observing;
Ways to ensure patient comfort during the examination or procedure;
Appropriate gowning or draping for privacy;
Suitable positioning in the room such that they can assess the nature of the contact between physician and patient;
How to intervene or stop an examination or procedure if they are concerned that the patient is distressed or that inappropriate contact has occurred;
Reporting mechanisms for concerns and non-compliance with established chaperone policy.

Chaperones may feel uncertain or hesitant about intervening during an examination or procedure, or about reporting misconduct. To establish expectations for the role of chaperones, institutions and practices should set policies for both physicians and chaperones in advance. They should also agree on methods of communication to signal patient distress or chaperone concerns while examinations or procedures are in progress [3].

Chaperones are responsible for upholding privacy and confidentiality. Since physicians are obligated to "seek to protect privacy in all settings to the greatest extent possible" opportunities should be provided for private conversation with the patient without the chaperone present. In addition, physicians should minimize inquiries or history taking during a chaperoned examination or procedure. If a patient shares information with the chaperone that is relevant to patient care but requests that this not be disclosed to the physician, the chaperone should make it clear that they cannot maintain confidentiality when this would endanger the health of the patient. The chaperone may also encourage the patient to either raise the issue with the physician themselves or obtain permission from the patient to communicate the information to the physician separately.

Chaperones must be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. As far as possible, lines of authority in the reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter [3]. Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care.

Expert consensus is that individuals for whom patient care is not a routine part of their ordinary duties (such as front desk or office support staff) should not function as chaperones [1,17]. It may be appropriate for medical students, residents, and fellows to perform the duties of chaperone, provided that special attention is paid to how these duties may be impacted by the power imbalance inherent in the trainee-supervisor relationship. Trainees should be provided with information about their role serving as a chaperone, sufficient knowledge about the procedure or interaction they will be observing, and how to report any concerns without repercussions, fear of retaliation, or other professional disadvantages. The standard approach is to have healthcare staff such as nurses, medical assistants or physician

assistants act as chaperones, provided they are fully trained in the responsibilities of the role. Occupying a dual role as chaperone and member of the care team is acceptable when the two sets of responsibilities do not conflict and are well understood by everyone involved. “Parents and other untrained individuals” should not act as chaperones, except in the case of young children, as discussed above [3,17].

Concerns may arise regarding the additional resources needed to implement current best practices for the use of chaperones. In particular, physicians may be concerned that these resources will be diverted away from patient care. However, it has been established that “most patients regard the offer of a chaperone as a sign of respect,” and further, that physician misconduct has significant detrimental effects on patient well-being, the patient-physician relationship, and the integrity of the profession as a whole [1,10]. In light of these considerations, the fact of limited resources or additional costs does not justify the failure to regularly employ chaperones for sensitive examinations and procedures, and/or to make them available in other situations at the patient’s request.

CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that alternate Opinion 1.2.4 be adopted in lieu of Opinion 1.2.4 and the remainder of the report be filed:

Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the professional boundaries of the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient’s personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive exams while also empowering patients. Such efforts include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They may also include the use of chaperones regardless of the gender of the physician or patient. Having chaperones present can help protect the integrity of the patient-physician relationship. Physicians should, as always, also be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. A fair and effective policy on the use of chaperones must balance: (1) respect for patient preferences and the integrity and safety of the clinical encounter; (2) protection of physicians; and (3) boundaries of the patient-physician relationship.

Physicians should:

(a) Provide a chaperone for all sensitive exams, with an option for patients to decline if they wish, unless the delay in obtaining a chaperone would result in significant harm to the patient. For all other types of examinations and procedures, patients must be informed that they are entitled to request a chaperone, and one should be made available when they make such a request. Physicians should honor patients’ request for a chaperone, even if a patient’s trusted companion is present.

(b) Provide an opportunity for private conversation with the patient without the chaperone present and minimize inquiries or history taking during a chaperoned examination or procedure.

(c) Make every effort to accommodate the preferences of the patient, consistent with the interests of patients, physicians and the maintenance of professional boundaries. If the patient and physician cannot arrive at a mutually acceptable arrangement, then the physician may facilitate transfer of care.

(d) Always use a chaperone for sensitive exams if the patient lacks the capacity to consent at the time of care, unless the delay in obtaining a chaperone would result in significant harm to the patient.

(e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician.

(f) Have an authorized member of the health care team act as a chaperone. All chaperones should be provided with information and understand the responsibilities of the role. Chaperones should be made aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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8. LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLINDED MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy H-370.954 was adopted at A-23 and asks that the Council on Ethical and Judicial Affairs (CEJA) consider amending Opinion 6.2.1, "Organ Transplantation from Deceased Donors," to address concerns regarding immigration status and access to donated organs.

BACKGROUND

Resolution 003-A-23 noted the profound disparities that exist in the United States between undocumented immigrants versus documented immigrants and citizens access to organ transplantation. For example, United Network of Organ Sharing (UNOS) data reveals that only 0.4 percent of liver transplants in the U.S. went to undocumented immigrants, while undocumented immigrants accounted for up to 3 percent of the total deceased liver organ donors in the U.S. [1].

AMA's ethical criteria for organ allocation were set out in a 1993 CEJA report on organ transplantation [2}. Ethical criteria for scarce resource allocation include the likelihood of benefit, change in quality of life, duration of benefit, urgency of need, and the amount of resources required for successful treatment. These criteria must be weighed in a complex analysis that takes into account all these criteria together.

Likelihood of benefit is aimed to "maximize the number of lives saved as well as the length and quality of life" [2]. Change in quality of life is a criterion that one maximizes benefit "if treatment is provided to those who will have the greatest improvement in quality of life", however defining what constitutes "quality of life" is difficult as it will "depend greatly on patients' individual, subjective values" [2]. Duration of benefit can be thought of as the length of time a patient can benefit from a treatment, which often will involve a calculus of life expectancy to be part of analysis; however, life expectancy is not always a determinative factor when making allocation decisions [2].

Urgency of need "prioritizes patients according to how long they can survive without treatment" [2]. The amount of resources gives higher priority to "patients who will need less of a scarce resource" in order to maximize the number of lives saved [2]. Resources in this context does not mean a patient's finances, but rather scarce medical resources like an organ, e.g. a patient who requires two organ transplants may be lower priority than someone who only needs one [2].

ETHICAL ISSUE

To what extent may non-medical factors such as immigration and/or socioeconomic status be considered in organ transplantation allocation decisions.

REVIEW OF RELEVANT LITERATURE

The ethical problem regarding "fairness" has been well documented, as undocumented immigrants "are able to, and do donate their organs, but they are effectively barred from receiving transplants" [3] or, after receiving transplants, may not have the proper resources down the line to receive continued therapies like immunosuppressive medications [4]. The Organ Procurement and Transplantation Network (OPTN) declares that "residency status cannot factor into decisions on whether to allocate an organ to a specific patient" [5]. The OPTN policy states: "A candidate's citizenship or residency status in the United States must not be considered when allocating deceased donor organs to candidates for transplantation. Allocation of deceased donor organs must not be influenced positively or negatively by political influence, national origin, ethnicity, race, sex, religion, or financial status" [6]. While OPTN's policy strives to achieve equity, the practical reality is that financial and socioeconomic considerations are indirectly weighed, as insurance coverage is usually needed for pre-and post-opt care.

Despite the perception that immigration status may affect health status, "unauthorized immigrants who receive liver transplants in the United States have comparable three-year survival rates to the U.S. citizens", indicating that survival outcomes are not drastically different for undocumented immigrants and that "concern for worse survival should not be used as a reason to deny access to liver transplant" [7]. Additionally, a cardiothoracic transplant study in the U.S. found that citizenship status was not relevant in determining transplant outcomes, noting that "citizenship status does not appear to be an independent determinate of early post-transplant outcomes", reinforcing that immigration status by itself is not a medically relevant characteristic in determining likely success of organ transplantation [8].

Lack of insurance is often the largest obstacle for undocumented immigrants seeking organ donation. Many undocumented immigrants who would otherwise be good candidates for an organ transplant do not have insurance to cover the surgical procedure or the long-term after care, and as a result are removed or not allowed on transplant wait lists [9]. Other practices, such as hospitals asking patients for Social Security numbers while making transplant eligibility assessment—though there is "no legal requirement to do"—also exclude undocumented immigrants from transplant eligibility, further contributing to disparities [10].

ETHICAL ANALYSIS

Numerous factors are involved in the allocation of organs and scarce resources and are all aimed at maximizing the "good", i.e. "number of lives saved, number of years of life saved, and improvement in quality of life" [2]. Opinion 11.1.3, "Allocating Limited Health Care Resources" addresses these criteria. The 1995 CEJA opinion on organ transplantation states that both social worth and ability to pay are not ethically justified criteria to make decisions on how to allocate scarce resources. Additionally, the ethical concerns raised by Res 003 are valid, in that immigrant status itself is being used as an indicator of financial status or socioeconomic status. However, the key aspects associated with the disparities of immigration status, "social worth" and "ability to pay", are both already addressed by H-370.982.

Not all undocumented immigrants have lower economic status. Some immigrants (undocumented or otherwise) may have strong financial means, e.g. wealthy foreign immigrants who travel the U.S. for medical care. Hence, specifically calling out "immigration status" or "undocumented status" is not ideal, as the term is not precise and does not always imply an individual without proper insurance or financial means or a person with lower socioeconomic status.

As previously discussed, it is impossible to truly separate medically relevant and non-medically relevant criteria in the context of organ donation. The *Code's* broader approach to generally avoid lists of specific examples of non-clinical characteristics allows physicians to make their own analysis about what is and is not clinically relevant in specific cases. There is clearly an apparent disparity between those who donate organs and those who receive them and we continue to have disparities in outcomes due to socioeconomic status. While finances and ability to pay are by themselves not medically relevant and in an ideal sense, should not be ethically considered, they often must be considered in the context of organ transplantation eligibility because they can affect the patient's ability to obtain the necessary resources or participate adequately in regiments to ensure the long-term viability of the transplant thus, becoming medically relevant; however, when these non-medical factors are not clinically relevant should not be considered. The result is an ethical tension that is effectively paradoxical. Leaving the paradox outside of the policy allows for more fluidity in interpretation of the *Code* in any context.

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:

When making organ transplantation allocation decisions, physicians have a responsibility to provide equitable and just access to health care, including only utilizing organ allocation protocols that are based on ethically sound and clinically relevant criteria.

When making allocation decisions for organ transplantation, physicians should not consider non-medical factors, such as socioeconomic and/or immigration status, except to the extent that they are clinically relevant.

Given the lifesaving potential of organ transplants, as a profession, physicians should:

Make efforts to increase the supply of organs for transplantation.

Strive to reduce and overcome non-clinical barriers to transplantation access.

Advocate for health care entities to provide greater and more equitable access to organ transplants for all who could benefit.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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9. ETHICAL IMPETUS FOR RESEARCH IN PREGNANT AND LACTATING INDIVIDUALS

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

HOUSE ACTION: REFERRED

Policy D-140.949, "Ethical Impetus for Research in Pregnant and Lactating Individuals," was adopted at the 2024 Annual Meeting and asks "that our Council on Ethical and Judicial Affairs (CEJA) consider updating its ethical guidance on research in pregnant and lactating individuals."
BACKGROUND

More than four million individuals give birth in the United States every year [1] and 70 percent of these individuals will require at least one prescription medication while pregnant [2]. Despite the widespread use of medications during pregnancy, most information about the efficacy and safety of medication used during pregnancy comes from the post-marketing setting and is not derived from clinical research trials [3].

Only a dozen medications have been approved by the United States Food and Drug Administration (FDA) for use during pregnancy, and those medications are for gestation- or birth-related medical issues [4]. Therefore, any medications utilized to treat chronic health conditions in pregnancy are used without FDA approval ("off label"). Only 2.4 percent of those commonly used medications for chronic health conditions have included pregnant individuals in controlled human clinical trials. The lack of clinical trial data is a result of the historical exclusion of pregnant and lactating individuals from clinical trials. Exclusion of pregnant and lactating individuals from clinical trials has often occurred due to the fear of harming the fetus or newborn, as well as concern that physiologic changes in pregnancy or

during lactation will impact the results of pharmacologic trials [3,5]. The effect of this exclusion is that physicians and patients are forced to make decisions about whether to utilize medications during pregnancy without adequate fetal and maternal safety data [6].

ETHICAL ISSUES

Pregnant and lactating individuals have been systematically excluded from clinical trials for decades out of concern for negative effects on fetuses and nursing infants. This exclusion has resulted in a paucity of evidence regarding safe and effective medication use in these groups of individuals. Due to the existing knowledge gaps surrounding the use of medications during pregnancy and breastfeeding, physicians and patients are faced with making treatment decisions without appropriately understanding the potential benefits and risks to both the pregnant individual and their fetuses or nursing infant. Additionally, these knowledge gaps prevent physicians from being able to appropriately counsel pregnant patients regarding the risks, benefits, and alternatives of treatments. At issue is how to balance respect for pregnant and lactating individuals with the potential benefits and harms of research.

REVIEW OF RELEVANT LITERATURE

Pregnant and lactating individuals have historically been considered "vulnerable" and subjected to additional research protections and exclusion from research [7]. This problem is known as the "protection-inclusion dilemma", whereby groups deemed "vulnerable" are "over-protected" and excluded from research, leading to justice issues including a "lack of relevant health data for under-represented populations" [8]. The consequence of the protection-inclusion dilemma is that most of the medications pregnant individuals are prescribed are not FDA approved for pregnancy. This is problematic because while "there are significant physiologic changes in pregnancy, including near doubling of maternal blood volume and alterations in binding proteins, the pharmacokinetics [PK] and efficacy of drugs in pregnancy are, by and large, unknown" [7]. This uncertainty for prescribers results in dosages labelled for use in nonpregnant individuals being used for pregnant individuals, "with little consideration for the PK changes that occur during pregnancy" [9].

Although the negative effects of excluding pregnant and lactating individuals in clinical trials have been noted for years, little has been done in that time to address the significant knowledge gaps in research that remain. For example, many Institutional Review Boards (IRB) "continue to regard pregnancy as a near-automatic cause for exclusion, regardless of the costs of exclusion or the magnitude or likelihood of the risks of participation," and the lack of research data leads to persistent disparities for chronic disease managements among pregnant individuals [5].

Relevant Laws

The FDA has several relevant regulations. 45 CFR 46, Subpart B "Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research", provides regulations regarding research involving pregnant individuals. 45 CFR §46.204 – "Research involving pregnant women or fetuses" states that:

Pregnant women or fetuses may be involved in research if all of the following conditions are met:
(b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means [10].

Additionally, as of January 21, 2019, the Common Rule no longer labels pregnant individuals as "vulnerable" with regards to IRBs. This is because while pregnant individuals have historically been deemed vulnerable, it has since been recognized that while some individuals who are pregnant may be vulnerable, being pregnant in and of itself does not automatically denote vulnerability [11,12].

Relevant Code Provision(s)

The *Code of Medical Ethics* encourages the inclusion of pregnant individuals in clinical trials, when appropriate, so long as the research "balance[s] 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" (Opinion 7.3.4). However, the *Code* also places constraints on physicians involved in maternal-fetal research, advising that they should "[e]nroll 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" (Opinion 7.3.4).

ETHICAL ANALYSIS

A multitude of historical, legal, scientific, and societal factors have resulted in the exclusion of pregnant and lactating individuals from clinical trials for decades. However, the ethical principle of justice necessitates that the benefits and burdens of research participation be fairly distributed across all groups, including pregnant and lactating individuals, because failure to do so produces disparities that impact both safety and quality of care for pregnant and lactating individuals, fetuses, and nursing infants.

Concerns for fetal safety have served as the primary justification for the exclusion of pregnant individuals from clinical trials for decades, but this exclusion has paradoxically resulted in substantial maternal and fetal harm. Because information about toxicity and dosing for pregnant and lactating individuals has not been determined through smaller scale and well-controlled clinical trials for most medications, far more pregnant and lactating individuals who require medications for chronic medical conditions are being exposed to potentially harmful medications via "off label" uses.

Examples of this harm can be seen in the historical use of thalidomide and diethylstilbestrol in pregnant individuals. While the tragic consequences of their use have been cited as reasons to exclude pregnant individuals from clinical trials, it was actually the lack of controlled data from clinical trials that caused such widespread detrimental effects due to the teratogenic effects of these drugs not being examined until post-marketing surveillance data was available. Had smaller scale and better controlled clinical trials been conducted, mass marketing and exposure to these medications for pregnant individuals may have been avoided because the teratogenic effects would have been discovered during trials [13]. Another example is that of ACE inhibitors, which were used in pregnant individuals for three decades prior to the 1996 discovery that its use in the first trimester can cause congenital anomalies [5]. Had it been studied more rigorously through smaller scale clinical trials with individuals consenting to the risks of participating in research, this discovery may have been made much sooner and far fewer individuals would have been exposed to this drug in the first trimester without knowing the risks of doing so.

Historically, concern for pregnant individuals and fetuses has centered on defining this population as "vulnerable", thus needing broad shielding from risks, such as medical research. Such an approach to research practices has been deemed "overly paternalistic, disempowering, or coercive" [14]. Pregnant and lactating individuals are not automatically vulnerable, and this approach does not respect their autonomy to assess the benefits and risks of participation for themselves and their fetuses or newborns [15]. Pregnant and lactating individuals should always be provided the opportunity to decide whether research participation is in their best interest through informed consent. If pregnant or lactating individuals are unable to be included in research, alternative ways to rectify any gap in knowledge should be developed. For example, pregnant and lactating individuals should be instructed on how to participate in research registries and adverse event reporting programs.

CONCLUSION

The historical exclusion of pregnant and lactating individuals from clinical trials has resulted in a lack of data about the appropriate safety, dosage, and efficacy of most medications in this group. This knowledge gap has created an ethical imperative to include more pregnant and lactating individuals in clinical trials. While consideration of maternal, fetal, and nursing infant well-being should be important criteria included in guidelines for research, wholesale exclusion of pregnant and lactating individuals from clinical trials comes with its own risk to fetal and maternal safety. Theoretical risks for fetal harm should not automatically be assumed to outweigh potential risks of ongoing nonparticipation. Currently, the *Code* does not reference this disparity. Nor does it refer to lactating individuals. It also does not contain gender neutral language, i.e. it references women and not individuals.

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends the following:

That a new Code of Medical Ethics opinion be adopted as follows:

Research involving pregnant and lactating individuals, including but not limited to, research regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses or nursing infants, must balance the health and safety of individuals who participate and the well-being of their fetuses or nursing infant against the desire to develop new and innovative therapies. Although it is important to carefully consider potential fetal risks involved when pregnant and lactating individuals participate in research, it is critical to realize that large scale exclusion from participation by these individuals has also precluded potential benefits and in some cases resulted in harm for this group. The paucity of data on safe and effective medical treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing between pursuing medical interventions with uncertain risks to themselves and their fetuses or nursing infants, or foregoing the interventions altogether, which might itself cause harm due to undertreatment of medical conditions.

Understanding both the potential risks of participation and of non-participation, physicians conducting research should adhere to general principles for the ethical conduct of research, and should:

(a) Include pregnant and lactating individuals in research, unless there is a significant clinical reason not to, in order to establish a greater knowledge base, produce relevant data, and promote respect for individuals.

(b) Obtain the informed, voluntary consent of the pregnant or lactating individual, as in all human participant's research.

(c) Where scientifically appropriate, base studies on well-designed, ethically sound research with animals and nongravid human participants that has been carried out prior to conducting research on pregnant and lactating individuals to better assess potential risks.

(d) Plan alternative ways to rectify any gap in knowledge, when it is not possible to enroll pregnant or lactating individuals in research.

(e) Ensure risks to the fetus or nursing infants are not greater than minimal, especially when the intervention under study is not intended primarily to benefit the fetus or infant, but rather for the development of important biomedical knowledge that cannot be obtained by any other means.
Policy D-140.949 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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10. THE PRESERVATION OF THE PRIMARY CARE RELATIONSHIP

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-140.948

Policy D-140.948, "The Preservation of the Primary Care Relationship," was adopted at the 2024 Annual Meeting. Item two of this policy asks:

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.

This report is in fulfillment of this directive.

BACKGROUND

There are concerns that some large health systems are restricting access to specialty care unless patients first change their primary care physician to one employed by their system, resulting in the disruption of well-established patient-physician relationships and continuity of care. This could be particularly challenging for patients whose insurance or socioeconomic status prevents them from changing their primary care physician (PCP). For instance, community health clinics/centers (CHCs), a core health-safety net for many in the US that provides primary care to anyone who walks through their doors, already suffer from limited access to specialty care, and requiring CHC patients to find a new PCP in order to receive specialty care, which can already be challenging to obtain, might not always be possible [1].

Finding a new PCP can also be a challenge in and of itself, as the US is experiencing a shortage of PCPs. An estimated 83 million Americans live in areas with insufficient access to primary care, and it is projected that by 2036, the US will face a shortage of over 68,000 primary care physicians [2,3]. Placing this burden on patients who are actively seeking needed care could easily and needlessly delay their care and lead to a break in the continuity of their care. Proponents argue that having physicians in the same network could improve coordinated care. Conversely,

maintaining current PCPs while simply working to improve communication could effectively uphold continuity of care while also supporting coordination. This may be especially important in rural areas.

Relevant AMA Policy

Our American Medical Association (AMA) has several relevant House policies, including
D-140.948, "The Preservation of the Primary Care Relationship," which states: "(1) 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. […] (3) 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."
H-160.901, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care," states: "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."

And H-285.944, "Disease Management and Demand Management," states: "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."

Relevant Code *Opinions*

The AMA *Code of Medical Ethics* also has several relevant Opinions that support the preservation of primary care relationships and patient-physician relationships more broadly. These include Opinion 1.1.1, "Patient-Physician Relationships," which states, ""[t]he relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare"; Opinion 1.1.3, "Patient Rights," which states that patients' rights include "courtesy, respect, dignity, and timely, responsive attention to his or her needs" as well as a right "[t]o continuity of care"; and Opinion 1.1.6, "Quality," which states, "physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable." Together, these opinions articulate physicians' obligations to prioritize patients' welfare and highlight the ethical importance of providing care that is timely, equitable, and continuous.

Also of note, Opinion 11.2.3, "Contracts to Deliver Health Care Services," states that physicians "should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients' interests." Relatedly, Opinion 11.2.1 "Professionalism in Health Care Systems," states that physicians in leadership positions within health care organizations should ensure that financial incentives and other tools "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;" Opinion 11.3.1 "Fees for Medical Services," states that physicians should not charge unnecessary fees "or fees solely to facilitate hospital admission"; and Opinion 11.3.4 "Fee Splitting" states that a fee solely for referral of a patient is unethical.

ETHICS ISSUE

Does requiring patients to switch to primary care physicians within a health system in order to access specialty care violate professional ethical obligations, such as continuity of care, and/or negatively impact the patient-physician relationship by violating the trust that is the foundation of the relationship and source of professional privilege for the practice of medicine?

ETHICAL ANALYSIS

Requiring patients to switch PCPs in order to access specialty care raises several ethical concerns regarding potential wrongs and harms that such requirements may cause. Principal among these concerns is that such requirements represent an undue barrier to care, that such barriers violate the trust fundamental to the patient-physician relationship, and ultimately undermine public trust in and respect for the practice of medicine.

The AMA *Code of Medical Ethics* is very clear that patients have a right to timely care that is responsive to their needs as well as to continuity of care (Opinion 1.1.3). Respect for these rights by the medical profession is what enables patients to trust that the obligations of the patient-physician relationship will be upheld. Timeliness is also a fundamental aspect of quality care (Opinion 1.1.6). Requiring patients to change PCPs in order to receive needed care could violate these ethical obligations.

Furthermore, such requirements raise concerns regarding issues of equity. If the patient populations of various insurance plans differ, such as those between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), it is likely that requirements regarding changing PCPs to access specialty care will have stronger impacts on certain patient populations than others. For example, compared to PPOs, HMO patient populations tend to be younger, with higher rates of Black and Hispanic patients [4]. Additionally, because HMOs are generally less costly than PPOs, they are likely to attract more people of lower socioeconomic backgrounds[5]. The *Code* is explicit in its insistence that all financial incentives and tools should be implemented fairly and in ways that do not disadvantage identifiable patient populations (Opinion 11.2.1).

CONCLUSION

As outlined in policy D-140.948, "The Preservation of the Primary Care Relationship," our AMA opposes the practice of "health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care." This policy stems from the 2024 Annual Meeting Resolution 014, "The Preservation of the Primary Care Relationship," the second resolve of which asked your Council on Ethical and Judicial Affairs (CEJA) to "review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists". This report is in fulfillment of the second resolve.

After review, CEJA has found that the AMA *Code of Medical Ethics* has several relevant Opinions that support the preservation of primary care relationships. These include Opinion 1.1.1, "Patient-Physician Relationships," Opinion 1.1.3, "Patient Rights," Opinion 1.1.6, "Quality," Opinion 11.2.3, "Contracts to Deliver Health Care Services," Opinion 11.2.1 "Professionalism in Health Care Systems," and Opinion 11.3.1 "Fees for Medical Services."
Existing Ethics and House policy are clear that the choice of who to see should be between patients and physicians. Such decisions should be based on the best interest of the patient. Policies that influence these decisions should be in accordance with physicians' professional and ethical obligations, and should support patient choice, continuity of care, equity, and the patient-physician relationship. Any practices that may compromise the patient-physician relationship should be closely examined with attention to these considerations. The *Code* opposes any practices that threaten to undermine patient-physician relationships.

RECOMMENDATION

The Council on Ethical and Judicial affairs recommends that Policy D-140.948(2) be rescinded as having been accomplished by this report.

Fiscal Note: Less than $500

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11. CEJA SUNSET REVIEW OF 2015 HOUSE POLICIES

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

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

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

In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

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

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

Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

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

Fiscal Note: Less than $500.

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
H-295.877	Medical Treatment of Prisoners of War and Detainees	Our AMA encourages medical schools to include ethics training on the issue of medical treatment of prisoners of war and detainees.	Retain; remains relevant.
H-295.961	Medicolegal, Political, Ethical and Economic Medical School Course	(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.	Retain; remains relevant.
H-410.987	Practice Parameters - Their Relevance	1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-	Retain; remains relevant.

	to Physician Credentialing	making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges. 2. The documentation of adherence to, or intent to practice within, relevant practice guidelines should not be used as an additional criterion for the granting of general or procedure-specific clinical privileges unless and until a relationship between adherence to such practice guidelines and desired patient outcomes is adequately documented. 3. Practice guidelines developed by a particular medical specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice guideline by physicians not formally credentialed in that specialty or specialties. Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges.	
H-450.973	Outcomes Research	1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others. 2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians. 3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and	Retain; remains relevant.

		evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality.	
H-460.898	Principles of Human Subjects Research Shall Apply to Online Medical Research Projects	Our American Medical Association declares social media sites' terms of service as an insufficient proxy for informed consent prior to being enrolled in any medical experiment and recommends that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of any medical experimental study prior to study enrollment.	Retain; remains relevant.
H-65.993	Abuse of Medicine for Political Purposes	The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur.	Retain; remains relevant.
H-85.952	Advance Directives During Pregnancy	1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship. 2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics. 3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.	Retain; remains relevant.

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following

sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

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

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2024 – MARCH 31, 2025

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
6	Determinations of no probable cause
11	Determinations following a plenary hearing
9	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
13	No sanction or other type of action
0	Monitoring
5	Probation
0	Revocation
5	Suspension
0	Denied
0	Suspension lifted
10	Censure
1	Reprimand[1]

Physicians Reviewed	PROBATION/MONITORING STATUS
8	Members placed on Probation/Monitoring during reporting interval
3	Members placed on Probation without reporting to Data Bank
14	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation

[1] Sanction no longer in use.

14	**Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues**
11	**Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues**

13. PRESUMED CONSENT & MANDATED CHOICE FOR ORGANS FROM DECEASED DONORS

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Resolution 017-A-24, "Addressing the Historical Injustices of Anatomical Specimen Use," Resolve 7, asks that our AMA amend Opinion 6.1.4 "Presumed Consent & Mandated Choice for Organs from Deceased Donors" as follows:

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:

Is scientifically well designed and defines clear, measurable outcomes in a written protocol.

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, n~~ Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

BACKGROUND

Increased organ donation from deceased donors results in lives saved, as one deceased organ donor can save up to eight lives through organ transplantation and improve the lives of up to 75 persons through tissue donation [1]. Although organ donation upholds utilitarian ethical principles, many deceased persons (prior to death) and their families as their surrogates (after death) choose not to donate. The most common reasons cited for choosing not to donate organs include mistrust of doctors, hospitals, and the organ allocation system as well as fears that the deceased persons organs will be sold on a black market or go to someone who does not deserve the organ (i.e. someone who brought on their own illness or is a "bad person") [2]. The widespread mistrust and fear associated with organ donation results in 17 people in the US dying every day while on the waiting list for an organ transplant [1].

Our AMA policy, including the *Code of Medical Ethics*, supports increasing the organ supply (Opinion 6.1.2) and promoting organ donation awareness (D-370.997) while also recognizing the need to "continue to monitor ethical issues related to organ transplantation" (H-370.967). Obtaining consent for organ donation, while an ethical imperative, may present a barrier to increasing organ supply (Opinion 6.1.2). There are three common methods of obtaining consent employed to facilitate organ donation including: 1) voluntary consent; 2) mandated choice; and 3) presumed consent. Although the voluntary consent model is traditionally used in the US and supported by *Code* guidance, our AMA has policy which supports "studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation" (H-370.959). Additionally, the *Code* provides guidance for physicians who propose to develop or participate in pilot studies of presumed consent and mandated choice (Opinion 6.1.4).

ETHICAL ISSUE

Resolution 017-A-24, Resolve 7 proposes striking the phrase "unless there are data that suggest a positive effect on donation . . ." from the guidance regarding the use of presumed consent and mandated choice models for organ donation as outlined in *Code* Opinion 6.1.4. Removal of this phrase would remove a caveat which provides an

opportunity for implementing presumed consent or mandated choice when data suggest a positive effect on donation. This ethical analysis weighs the benefits and burdens of adopting a more restrictive informed consent model for organ donation.

ETHICAL ANALYSIS

The *Code of Medical Ethics* requires that informed consent be obtained from the patient or their surrogate prior to organ donation. Among the three methods of informed consent for organ donation (voluntary consent, mandated choice and presumed consent), the *Code* supports voluntary consent (Opinion 6.1.2); however, each of the three methods of consent has advantages and drawbacks. Voluntary consent prioritizes individual autonomy by having potential donors make a voluntary decision to donate organs. While voluntary consent upholds autonomy, its opponents claim it results in a lower donation rate due to passive decision-making. Mandated choice takes consent to a more stringent level by requiring everyone to state their organ donation preference when executing a state supported document, such as receiving a driver's license, potentially resulting in a higher donation rate; however, this system also raises concerns of coercion which may undermine voluntary consent [3]. Conversely, presumed consent operates under an opt-out system which assumes consent to donate unless a person has explicitly registered their refusal to donate. While opt-out systems have the potential to result in the highest yield for organ donation, these systems may exacerbate distrust in the health care system and place additional stress on families who may not be aware of their deceased loved ones wishes regarding organ donation [4]. Additionally, opt-out systems raise ethical concerns surrounding respect for autonomy and voluntary consent.

In a 2005 CEJA report on Presumed Consent and Mandated Choice for Organs from Deceased Donors, the model of voluntary consent was adopted due to the need for data from research studies regarding whether ethically appropriate models of presumed consent or mandated choice would result in a positive effect on organ donation [5]. In the 20 years since this CEJA report was adopted, different models of consent have been utilized worldwide with varying impacts on organ donation models. A 2019 study assessing the effect of opt-out and opt-in approaches to organ donation across 35 similar countries found no significant difference in deceased-donor rates in per million populations [6]. However, a 2019 systematic review of opt-out versus opt-in consent models found that opt-out consent increases both deceased donation rate and deceased transplantation rates [7]. At a macro level, studies comparing aggregate donation rates across countries have reached different conclusions, a trend which is also observed when looking at donation systems at a micro level. For example, in 2015 Wales introduced an opt-out system which over time significantly increased organ donation consent [8]. Whereas Chile, Singapore, and Sweden provide examples of opt-out systems failing to increase donation [9].

While the data regarding whether opt-in versus opt-out models of consent increase deceased organ donation remain inconsistent, ethics concerns with each model persist which require consideration. From an ethical perspective, voluntary consent upholds patient autonomy and maximizes trust and transparency within the health care system; whereas presumed consent systems may undermine patient autonomy and diminish trust in the health care system [10]. However, voluntary consent models require healthcare professionals to obtain consent from the families of potential donors at the bedside during an emotionally difficult time. This is often without the knowledge of what the patient would have wanted. It is estimated that obtaining family voluntary consent at the bedside for organ donation results in an estimated 15-45 percent loss in potential deceased donors in the US [10].

CONCLUSION

The *Code of Medical Ethics* requires that informed consent be obtained from the patient or their surrogate prior to organ donation and prioritizes the voluntary choice model of consent. Due to the low rate of organ donation and high need in order to save lives, there is an active call to increase organ donation supply through the implementation of mandated choice or presumed consent models. Currently, the *Code* provides guidance that "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." However, the *Code* also recognizes that "these models merit further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh ethical concerns" (Opinion 6.1.4).

If the phrase "unless there are data that suggest a positive effect on donation" is removed, *Code* guidance on the utilization of presumed consent and mandated choice models for organ donation will become more stringent and effectively result in guidance to not widely implement either of these two consent models, even when data suggest a positive effect on donation. Given the pressing need for an increase in organ donation and the paucity of conclusory

data regarding the effect of consent model type on donation, effectually disallowing a model of informed consent for organ donation when data suggest a positive effect on organ donation would undermine the well-being of potential recipients waiting for a lifesaving organ donation. However, it is important to ensure that regardless of what the data show, the chosen consent model must be ethically implemented to respect both the donor and the recipient and must keep with ethics standards on informed consent and guidance for organ transplantation from deceased donors (Opinion 6.2.1).

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Resolution 17-A-24 not be adopted and the remainder of this report be filed.

Fiscal Note: Less than $500

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14. ACHIEVING GENDER-NEUTRAL LANGUAGE IN THE AMA CODE OF MEDICAL ETHICS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2024 Annual Meeting of the House of Delegates, Resolution 009, "Updating Language Regarding Families and Pregnant Persons" was adopted as a directive to take action. Resolution 009 contains one resolve which states that the American Medical Association (AMA) "review and 4 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."

Additionally, at the 2023 Annual Meeting of the House of Delegates, Resolution 602, "Supporting the Use of Gender-Neutral Language" was adopted as House Policy, H-65.942, "Supporting the Use of Gender-Neutral Language." H-65.942 states that the AMA "will recognize the importance of using gender-neutral language such as gender neutral

pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity" and that the AMA "will prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes."

RECONCILIATIONS

In response to the House's directives of Resolution 009 and H-65.943, the Council on Ethical and Judicial Affairs (CEJA) has searched the *AMA Code of Medical Ethics* for all *Code* opinions that contain the following non-gender neutral terms: obstetric, pregnant, pregnancy, mother, father, he, she, him, her, his, man, men, woman, and women and have applied appropriate alternate language for these terms. Ongoing review of gendered language should continue prospectively as policy states.

Where changes to *Code* language will be made, additions are shown with underscore and deletions are shown with strikethrough in red font. Given the length of many of the policies, only the affected portions are reproduced.

Appendix A includes relevant portions of *Code* opinions that contain gendered language and the alternative gender-neutral language.
Appendix B contains other *Code* opinions with gendered language that is relevant to the intent of the opinion and would substantively change the opinion if replaced with gender neutrallanguage. Therefore, the following policies will be retained as written.

The policy changes reflected in this report do not reset the sunset clock and will be implemented when this report is filed.

Fiscal Note: Less than $500

Appendix A – Alternative gender-neutral language

***Code* Opinion**	**Alternative Language**
1.1.2 Prospective Patients	Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by ~~his or her~~their other patients.
1.1.3 Patient Rights	To courtesy, respect, dignity, and timely, responsive attention to ~~his or her~~their needs.
2.1.2 Decisions for Adult Patients Who Lack Capacity	Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on ~~his or her~~their behalf. how the patient constructed ~~his or her~~their life story;
2.1.6 Substitution of Surgeon	A surgeon who allows a substitute to conduct a medical procedure on ~~his or her~~their patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.
2.2.2 Confidential Health Care for Minors	Explore the minor patient's reasons for not involving ~~his or her~~their parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

2.2.3 Mandatory Parental Consent to Abortion	Encourage the minor patient to involve ~~his or her~~their parents and offer to facilitate conversation between the patient and the parents. Strongly encourage the patient to discuss the pregnancy with ~~her~~their parents (or guardian). Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve ~~her~~their parents, encourage ~~her~~them to seek the advice and counsel of adults in whom ~~she has~~they have confidence, including professional counselors, relatives, friends, teachers, or the clergy. Not feel or be compelled to require a minor patient to involve ~~her~~their parents before ~~she decides~~they decide whether to undergo an abortion.
2.2.4 Treatment Decisions for Seriously Ill Newborns	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~~themself,
2.2.5 Genetic Testing of Children	Decisions to test must balance multiple considerations, including likely benefits, the risks of knowing genetic status (including abrogating the child's opportunity to make the choice about knowing genetic status ~~him- or herself~~themself as an adult),
3.2.1 Confidentiality	the patient will seriously harm ~~him/herself~~themself;
3.3.1 Management of Medical Records	This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells ~~his or her~~their practice, retires, or dies. to the succeeding physician or other authorized person when the physician discontinues ~~his or her~~their practice (whether through departure, sale of the practice, retirement, or death);
3.3.3 Breach of Security in Electronic Medical Records	The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on ~~his or her~~their awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.
4.2.3 Therapeutic Donor Insemination	Therapeutic donor insemination using sperm from a ~~woman's partner~~prospective patient or a third-party donor can enable a ~~woman~~patient or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents). However, the procedure also raises ethical considerations about safety for the ~~woman~~patient and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.

4.2.4 Third-Party Reproduction	Third-party reproduction is a form of assisted reproduction in which a ~~woman~~person agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of ~~his or her~~their birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged womenpersons, and commodify human gametes and children.
5.1 Advance Care Planning	Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express ~~his or her~~their own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to ~~his or her~~their surrogate and others to help ensure it will be available when needed. Periodically review with the patient ~~his or her~~their goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating ~~his or her~~their advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.
5.2 Advance Directives	Ascertain whether the patient has an advance directive and if so, whether it accurately reflects ~~his/her~~their current values and preferences.
5.3 Withholding or Withdrawing Life-Sustaining Treatment	Decisions to withhold or withdraw life-sustaining interventions can be ethically and emotionally challenging to all involved. However, a patient who has decision-making capacity appropriate to the decision at hand has the right to decline any medical intervention or ask that an intervention be stopped, even when that decision is expected to lead to ~~his or her~~their death and regardless of whether or not the individual is terminally ill.
5.4 Orders Not to Attempt Resuscitation (DNAR)	Physicians should address the potential need for resuscitation early in the patient's course of care, while the patient has decision-making capacity, and should encourage the patient to include ~~his or her~~their chosen surrogate in the conversation. Before entering a DNAR order in the medical record, the physician should: When the patient cannot express preferences regarding resuscitation or does not have decision-making capacity and has not previously indicated ~~his or her~~their preferences, the physician has an ethical responsibility to:

6.1.1 Transplantation of Organs from Living Donors	Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, ~~his or her~~their reasons for doing so will be kept confidential.
6.1.5 Umbilical Cord Blood Banking	Physicians who provide obstetrical care should be prepared to inform pregnant ~~women~~individuals of the various options regarding cord blood donation or storage and the potential uses of donated samples. Encourage ~~women~~people who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:
6.2.2 Directed Donation of Organs for Transplantation	Refuse to participate in any transplant that ~~he or she believes~~they believe to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.
7.1.2 Informed Consent in Research	For these reasons, no person may be used as a subject in research against ~~his or her~~their will. The participant gives ~~his or her~~their assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
7.1.4 Conflicts of Interest in Research	Ensure that the research protocol includes provision for funding participants' medical care in the event of complications associated with the research. A physician should not double-bill a third-party payer for additional expenses related to conducting the trial if ~~he or she has~~they have already received funds from a sponsor for those expenses.
7.2.3 Patents & Dissemination of Research Products	A patent grants the holder the right, for a limited time, to prevent others from commercializing ~~his or her~~their inventions.
7.3.2 Research on Emergency Medical Interventions	The prospective participant lacks the capacity to give informed consent at the time ~~he or she~~they must be enrolled due to the emergency situation and requirements of the research protocol and it would not have been feasible to obtain
7.3.4 Maternal-Fetal Research	Maternal-fetal research, i.e., research intended to benefit pregnant ~~women~~individuals and/or their fetuses, must balance the health and safety of the ~~woman~~individual 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~~individuals 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~~individual and fetus that they would in providing clinical care. Enroll a pregnant ~~woman~~individual in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the ~~woman~~individual or fetus. Obtain the informed, voluntary consent of the pregnant ~~woman~~individual.

	Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant ~~woman~~individual.
7.3.5 Research Using Human Fetal Tissue	However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which an ~~woman~~'sindividual's decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues. To protect the interests of pregnant ~~women~~individuals as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should: In all instances, obtain the ~~woman's~~individual's voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the ~~woman~~ individual of a right to refuse to participate. the ~~woman's~~ individual's decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes; decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant ~~woman~~individual.
9.4.4 Physicians with Disruptive Behavior	Establish a process to notify a physician that his or hertheir behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.
9.6.1 Advertising & Publicity	There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herselfthemself as a physician through any commercial publicity or other form of public communication
10.2 Physician Employment by a Nonphysician Supervisee	If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, the personal and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or hertheir employer.
10.3 Peers as Patients	Provide information to enable the physician-patient to make voluntary, well-informed decisions about care. The treating physician should not assume that the physician-patient is knowledgeable about his or hertheir medical condition.
10.6 Industry Representatives in Clinical Settings	The representative has agreed to abide by the policies of the health care institution governing his or hertheir presence and clinical activities.

11.3.1 Fees for Medical Services	Charge only for the service(s) that are personally rendered or for services performed under the physician's direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit ~~his or her~~their own bill to the patient and be compensated separately.

Appendix B - Policies retained as currently written

4.1.2. Genetic Testing for Reproductive Decision Making	Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family historyor medical record indicated elevated risk for a limited set of genetically mediated conditions.