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REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-25

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration. The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

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

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

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

Review of the materials and discussion during the SSS meeting at the November 2024 Interim Meeting indicated that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX
Exhibit A

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

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Emergency Medicine*	1,727 of 6,270 (28%)
American Society for Laser Medicine and Surgery, Inc.	323 of 1,156 (28%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-25

Subject: Physician Assisted Suicide

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 004, "Study of Physician Assisted Suicide and Medical Aid in Dying," which was introduced by the Medical Student Section. This resolution asked our American Medical Association (AMA) to:

> Oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying
>
> Use the term "medical aid in dying" instead of the term "physician assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions
>
> Rescind our HOD policies on physician assisted suicide, H-270.965 "Physician Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue
>
> Amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
>
> > Our AMA believes that:
> >
> > (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
> >
> > (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
> >
> > (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
> >
> > ~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient~~

~~autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~

(5) Our AMA supports continued research into and education concerning pain management

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

BACKGROUND

Physician assisted suicide occurs when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform a life-ending act" [1]. This act is sometimes referred to using other terminology such as medical aid in dying. Currently, there is no federal law governing physician assisted suicide; therefore, individual states are permitted to determine their own legal stance. At this time, 10 states and the District of Columbia permit this practice; however, most states have legislation banning this practice [2]. Furthermore, two states have removed their residency requirement, effectively opening the practice of physician assisted suicide more broadly to patients throughout the US.

Our AMA has a long-standing policy (H-270.965) opposing the legalization of physician assisted suicide. That said, our AMA is also opposed to the criminalization of physician medical judgement and the regulation of medical practice through criminal penalties (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999). Additionally, our AMA has policy preserving a physician's right to exercise their autonomy (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

DISCUSSION

The referred resolution addresses several issues encompassed within the broad context of physician-assisted suicide: terminology, opposition to the legalization and practice of physician assisted suicide, and opposition to the criminalization of physician participation in assisted suicide. This report addresses these topics in the context of our AMA's current HOD policies and Code of Medical Ethics guidance. In addition, the Council on Ethical and Judicial Affairs has produced two informational reports to further discuss the ethical complexity of these topics as they relate to physician assisted suicide and the practice of medicine.

Terminology

The terminology used in the AMA Code of Medical Ethics and HOD policy to describe this practice offers a clear delineation of intent and action. The use of other terminology to describe this practice has the potential to confuse patients and unduly influence decision making [5]. Descriptors such as Medical Aid in Dying (MAID), physician aid-in-dying, and death with dignity could apply to palliative care practices and compassionate care near the end of life that do not include intending the death of patients. In CEJA Report 2-A-19, "Physician Assisted Suicide," the Council determined that PAS was the terminology which described the practice best. The report supported this supposition with the following analysis which remains valid:

The Council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the Council's view, despite its negative connotations, the term "physician assisted suicide" describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

Opposition to the legalization and practice of physician assisted suicide

AMA policy opposes the legalization and practice of physician assisted suicide stating that it is "fundamentally incompatible with the physician's role as a healer" [1]. In developing CEJA Report 2 (A-19) which informed our AMA's current ethics standards on physician assisted suicide, the Council on Ethical and Judicial Affairs analysis 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.

Although legislative developments since 2019 have occurred, recent empirical data reviewing physician assisted suicide practices in US and international jurisdictions where PAS and/or euthanasia are legal are subject to varied interpretations. As a matter of ethical reasoning, the data does not settle the ethical issue. Additionally, the relevant core ethical values at stake have not changed since the adoption of CEJA Report 2 (A-19). As such, the AMA's position on physician assisted suicide should remain unchanged.

Of note, the AMA's position on physician assisted suicide is not a position of neutrality and establishes that the profession of medicine should not support the legalization or practice of physician assisted suicide or see it as part of a physician's role.

Opposition to the criminalization of physician participation in assisted suicide

While AMA policy opposes the legalization of or participation in physician assisted suicide, this stance must also be balanced with AMA policies opposing criminalization of physician medical judgement within the confines of the law and the use of criminal penalties to regulate medical practice. As a physician's choice to engage in the practice of physician assisted suicide is considered by many to be a medical judgement, failing to oppose criminalization of physicians who engage in physician assisted suicide may be contrary to the AMA's long-standing opposition to interference with physician medical judgement. To wit, the AMA's recognition that physicians may have differing aspects of conscience is upheld in the *Code of Medical Ethics,* which states that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician assisted suicide." Additionally, the *Code* Appendix to the opinion on physician assisted suicide notes that the AMA *Code* preserves the opportunity for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice." [2]. In essence, if after due moral consideration, a physician decides to participate in the practice, they will be judged to have acted conscientiously, consistent with the AMA *Code* [3].

If after due moral consideration, a physician exercises their autonomy, conscience, and medical judgement to participate in physician assisted suicide, our AMA should uphold its long-standing opposition to the criminalization of physician medical judgement and the imposition of criminal penalties on medical practice. Opposing criminalization of physicians who engage in physician

assisted suicide, while simultaneously not supporting the legalization of this practice, will allow our AMA to uphold its existing core values including not supporting the legalization of the practice of physician assisted suicide (H-270.965, *Code of Medical Ethics* Opinion 5.7), opposing criminalization of physician medical judgement and health care decisions (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999, D-160.999), and allowing physicians to uphold their conscience (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

It is important to distinguish between opposing the legalization of physician assisted suicide and opposing the criminalization of physicians who engage in the practice within the confines of the law in the jurisdiction in which they practice as an exercise of their medical judgement. Opposing legalization refers to our AMA organizational stance against the *practice* of physician assisted suicide, whereas criminalization refers to our AMA organizational stance regarding the *consequences* to physicians for engaging in the practice of physician assisted suicide. Additionally, criminalization is different from a civil penalty in that criminalization has a potential consequence of incarceration, whereas a civil penalty only carries a financial consequence.

Additionally, in keeping with AMA policy of protecting the patient-physician relationship, including protecting patients who engage in shared-medical decision making with their physician and patient exercise of autonomous medical decision making and information consent (H-165.837, *Code* 2.1.1, and 1.1.3), it follows that our AMA should oppose the criminalization of patients engaging or attempting to engage in physician assisted suicide at their request, with their informed consent.

CONCLUSION

While AMA policy opposes legalization of physician assisted suicide, it also upholds the principles that medical judgement should not be subject to criminal penalties and remains committed to protecting the integrity of the patient-physician relationship.

RECOMMENDATIONS

The Board of Trustees recommends adoption of the following in lieu of the Resolution 004-I-23, "Study of Physician Assisted Suicide and Medical Aid in Dying" and the remainder of this report be filed:

Our American Medical Association opposes:

(1) Civil or criminal legal action against physicians and health professionals who legally engage in physician assisted suicide at a patient's request and with their informed consent.

(2) Civil or criminal legal action against patients who engage or attempt to engage in physician assisted suicide.

Fiscal Note: Minimal – Less than $500

REFERENCEES

1. American Medical Association. *Code of Medical Ethics* Opinion 5.7 Physician Assisted Suicide. Physician-Assisted Suicide | AMA-*Code* (ama-assn.org)
2. States Where Medical Aid in Dying is Authorized. Compassion & Choices. Accessed August 21, 2024. https://compassionandchoices.org/resource/states-or-territories-where-medical-aid-in-dying-is-authorized.
3. American Medical Association. *Code of Medical Ethics*. Opinion 1.1.7 Physician Exercise of Conscience. Physician Exercise of Conscience | AMA-*Code* (ama-assn.org).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-25

Subject:	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Ethics and Bylaws

At the 2024 Annual Meeting, the House of Delegates (HOD) adopted Resolution 001, Resolved 2, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," resulting in policy D-460.962, which directs our AMA to: "develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing." This report is in fulfillment of this second directive from D-460.962.

BACKGROUND

Burnout represents a serious health crisis for physicians and other health care practitioners. Burnout compromises physician well-being and can negatively impact the quality of care that physicians provide to their patients [1]. The COVID-19 pandemic greatly exacerbated rates of burnout, with prevalence among physicians rising from 38.2 percent in 2020 to 62.8 percent in 2021 [2]. Drivers of burnout include increasing administrative burdens, lack of support from physicians' institutions and health care systems, changing political and legal landscapes, and other disruptions to the patient-physician relationship.

Since the height of the pandemic, the rate of burnout has trended downward, reaching below 50% in 2023 for the first time in four years [3]. Contributing to this decline are various health systems' initiatives to promote professional well-being, including hiring more staff, creating opportunities for coaching and leadership development, appointing wellness officers, and attempts to afford physicians greater flexibility and autonomy [4].

Though burnout is widespread throughout the medical profession, it is highly contextual and can manifest in different ways and to different extents depending on the individual and on the practice, institution, or health system in which the physician works. As such, health systems have increasingly turned to data to help guide and tailor their resources and efforts to support physician well-being, including using physician personal health information and biological data to inform interventions to reduce burnout [5]. However, how such physician information is collected and used raises ethical concerns.

The collection and use of physicians' personal health information and/or biological data raises ethical issues related to consent, privacy, confidentiality, and data security. Additionally, the collection and use of such data to help reduce burnout raises questions of accountability regarding who is ultimately responsible for implementing changes to reduce burnout, and risks shifting the focus of burnout reduction interventions from organizational strategies to individual physician behavioral changes, placing the burden of reducing burnout directly on physicians themselves.

DISCUSSION

There is general agreement within the medical profession that more needs to be done to reduce burnout and improve physician well-being. Because individual personal health information and biological data can provide valuable insights into physical and mental health, the collection and use of such data offer potential avenues to support the well-being of healthcare professionals, including the early identification of burnout and the development of evidence-based prevention strategies. The Internet of Things (IoT), which, in relation to health data, refers to a network of connected medical devices, such as wearable sensors that continuously capture various health metrics, including heart rate, blood pressure, sleep levels, and blood glucose levels, and transmit this information wirelessly in real time to a health care platform, has made it easier than ever to collect and monitor personal health information and has been promoted as a potential tool for combating physician burnout. Many physicians already use such wearable technologies as tools for self-monitoring and behavioral modification to promote well-being. However, while the collection and use of physicians' personal health information may help to identify and reduce burnout, doing so also poses serious concerns regarding efficacy, privacy, ethical data collection, and accountability.

Validity and Relevance of Collected Data

A primary concern raised with respect to relying on personal health information and/or biological data to reduce burnout is whether the observable data can accurately reflect the underlying subjective sense of well-being and mental health associated with burnout [6]. There are numerous factors associated with burnout, and the relationships between these factors are complex; furthermore, failure to accurately model this dynamic will inevitably result in a failure to adequately capture burnout. While substantive research has been done on physician burnout, there is no clear consensus on the definition or on how to assess it [7].

In their critique of the bio-psycho-social model of burnout (a framework that emphasizes the interconnectedness of biology, psychology, and social factors in human health and illness), Listopad et al identify a total of 40 factors related to burnout and conclude that the bio-psycho-social model is insufficient to identify all the factors and explain the pathogenesis of burnout; they propose extending the model to include spiritual and work culture dimensions that also impact burnout [8]. In addition to biological and psychological factors, which might be more readily detected via personal health information, Listopad et al show that socio-environmental factors, spirituality, and work culture also play an important role in the onset of burnout, which poses a problem for any data-based detection of burnout that fails to include these dimensions [8]. As Adler et al explain:

> Unlike illnesses solidly grounded in biological mechanisms, mental health and well-being is so fluid, psychosocial, and personal a construct that its indicators are necessarily up to individual interpretation—to monitor sleep and sociality in a potentially depressed person is not to monitor blood glucose in a person with diabetes. Removing a patient's ability to provide interpretation—their "right to self-presentation"—risks endorsing a fully data-centric perspective on well-being, one that might flatten necessary subjectivity [6].

Questions thus remain regarding what data best represents physician well-being and burnout, and how that data should be utilized.

Privacy and Confidentiality of Collected Data

Additional concerns regarding the collection and use of personal health information and/or biological data to reduce burnout center around issues related to privacy, confidentiality, data security, consent, and autonomy. There is general agreement among scholars that collecting and analyzing personal sensing data, the kind recorded by IoT technologies, poses real challenges to current norms around privacy, especially regarding the relationship between physicians and their supervisors [9]. Such challenges include concerns that personal data used to enhance professional well-being might blur the boundaries between work and life contexts, might recast physicians as patients, and that anonymity might be functionally impossible [6].

A central issue that emerges is how to balance respect for privacy with program utility. The challenge that arises is that anonymizing data is generally recognized as decreasing the utility of that data for improving individual-level well-being [6]. Research using protected health information (PHI) generally requires stricter privacy protections than de-identified data used for quality assessment (QI) or quality improvement (QI). However, even de-identified data risks re-identification, and it is highly likely that at small health care institutions anonymity of physician data would be impossible. Furthermore, even if anonymity were possible, reporting on average values derived from de-identified datasets defeats the purpose of identifying individuals struggling with burnout.

While informed consent has been considered the key tool to remediate concerns regarding data privacy and confidentiality, Adler et al note with respect to personal sensing data, consent is not the same thing as an ongoing data use agreement [6]. An ongoing data use agreement (DUA) is a legal contract that outlines how specific data can be used and shared between parties, essentially governing the access and usage of sensitive information once it has been collected, whereas informed consent is a process in which individuals are given detailed information about a medical intervention or data collection activity before agreeing to participate. While an informed consent agreement primarily focuses on an individual's understanding of a medical intervention and their right to participate in it, a DUA focuses on the restrictions and permitted uses of collected data once it is shared. Such data sharing by physicians raises related concerns including who owns the data, how it is to be protected, and assurance that it will only be used to improve physician well-being.

Ethical Data Collection

Sharing personal health information, which could be collected even during non-working hours, potentially blurs the boundaries between physicians' work and personal lives and could be considered a violation of their privacy. Passive data collection and sharing also violates physicians' control over disclosure and may violate their autonomy. Any data collection program aimed at improving physician well-being would thus require an opt-out option, though it should be noted that opting out could negatively impact the overall quality of the data captured and negate any individual-level burn-out interventions. Relatedly, physicians should recognize that they have a duty to promote occupational health, though meeting this obligation should not come at the cost of violating their own individual rights.

To limit or reduce the risk of violations to physicians' privacy and autonomy, a crucial aspect of any such burnout reduction program would be a requirement to obtain the informed consent of any participating physicians, and would likely require the implementation of a DUA as well. In determining whether such a program would allow physicians to voluntarily opt-in or require them to voluntarily opt-out, it is important to acknowledge that, while opt-in policies may reduce the

likelihood of participation and thus decrease the quality of any datasets obtained, opt-in policies do preserve the autonomy of physicians more than opt-out policies. Furthermore, it is imperative that anyone developing such programs recognize that the more data that is collected, the more personal the data is, and the more identifiable the information is all contribute to increasingly higher standards of physician protections that need to be in place.

Accountability

Current practices of physician performance profiling should be considered a warning sign about the likelihood that physician personal and/or biological data will be used only to improve physician well-being. The two main types of physician profiling in the US are clinical profiling and economic profiling, which examine a physician's treatments and outcomes of care or their financial performance (including cost and utilization of services), respectively. While, ideally, profiling should provide physicians with meaningful information on their clinical performance to help improve the quality of the services they provide, such profiling has largely become a tool for hospitals and other health care entities to control costs rather than as a method of measuring and improving quality of care [9]. Such developments raise questions about whether programs that use physician personal and/or biological data will actually use that data to serve physicians' best interests.

The focus on individual physician data also raises concerns regarding who may be seen as accountable for making improvements. The collection of individual physician data places an emphasis on individual behaviors rather than on institutional changes, which the consensus of researchers believe is necessary to significantly reduce burnout [10]. As Olson et al note, ameliorating burnout requires a systems approach and that organization-level interventions are far more effective at reducing burnout than individual-based interventions [10]. Rather than focusing only on programs aimed at promoting individual physician resiliency, Olson et al suggest that health care entities can reduce burnout by promoting workplace efficiency, supporting work-life integration, and granting greater physician control and autonomy over clinical decision-making and practice management in conjunction with promoting personal resilience [10].

Ultimately, collecting and using physician personal health information and/or biological data to improve physician well-being should only be implemented if the data is used solely to ameliorate stress-causing working conditions with clear accountability within the program regarding who is responsible for instituting those improvements. Any use of physician personal health information or biological data for other ends, such as improving operational efficiency, especially any ends that could be perceived as retaliatory or perpetuating unjust biases, should be avoided.

RELEVANT AMA POLICY AND RESOURCES

It deserves to be noted that all physicians are at times likely to also be patients and suffer their own illnesses and injuries that require medical attention. In their capacity as patients, physicians enjoy the same rights as any other patient as outlined in the AMA *Code of Medical Ethics* (see Opinion 1.1.3, "Patient Rights") [11]. Like any patient, they are entitled to receive quality care (Opinion 1.1.6), to informed consent (Opinion 2.1.1), to have their privacy respected (Opinion 3.1.1), and to have their de-identified data handled with care (Opinion 3.3.4) [12-15].

In their capacity as physicians, they also have obligations to practice continual self-awareness and self-observation to ensure that they are competent to practice medicine (Opinion 8.13), to strive to promote their own health and wellness (Opinion 9.3.1), and to intervene with respect and compassion in the event that they discover a colleague is not able to practice safely (Opinion 9.3.2)

[16-18]. Any programmatic collection and use of physician data, especially that which might be considered private health information, must adhere to the ethics guidance outlined in the AMA *Code of Medical Ethics*.

The collection and use of physician data raises several concerns, including issues related to privacy and consent, access and appropriate use, and the potential for coercion and discrimination. To protect physicians whose data is collected and used to improve physician well-being, it is therefore crucial that, in addition to the AMA *Code of Medical Ethics*, the AMA Privacy Principles be followed [19]. These principles, derived primarily from AMA HOD policy, were developed to provide individuals with data rights and protections from data holders other than HIPAA-covered entities. These guidelines provide broad guardrails to address individual rights, equity, data stewardship and related entity responsibilities, appropriate applicability, and enforcement. Any programmatic collection and use of physician data to improve well-being must also recognize that different specialties will likely require custom solutions, that different sized institutions will likely require tailored solutions, and that, generally, one-size-fits-all interventions are likely to be ineffective. Lastly, the collection of physician data is likely to be insufficient on its own to reduce burnout—physician engagement and collaboration will be crucial to successfully operationalize the collection and use of physician data to reduce burnout and improve physician well-being.

CONCLUSION

As technologies advance, the workplace is becoming increasingly quantified, with data analytics being used to identify opportunities for optimization and to improve productivity. The implementation of new tools for the collection and use of data is remaking the boundaries of appropriate information flows and will continue to have a growing impact on physicians and the practice of medicine. The collection and use of physicians' personal health information and/or biological data has the potential to help reduce burnout and improve physician well-being; however, the practice also creates several ethical dilemmas and should not be viewed as a panacea.

Further research is needed to better capture and define the lived experiences of burnout and well-being. Prior to implementation, policy protections should be developed to hold supervisors and administrators accountable and ensure that such programs are truly physician-centered and do not place the onus of preventing burnout on those suffering from it. Additionally, new policies and relational norms will need to be developed to protect physician data, prevent abuse of the power differential between data subjects and the data recipients, and ensure that such data is used solely for improving physician well-being and not in any way that could be perceived as retaliatory [6].

In light of these observations, the medical profession may consider collecting physician data to improve well-being but should do so with extreme caution. Furthermore, when collecting physician data, it is imperative that the AMA *Code of Medical Ethics* and AMA Privacy Principles be followed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. With the aim of promoting physician well-being in the workplace, physician personal health information and/or biological data should be:

a. Collected only if evidence supports that the specific data being collected is minimized to only that which is relevant and necessary to the development of interventions which promote physician well-being and reduce professional burnout;

b. Collected only if physicians are informed whether the data is directly or indirectly identifiable;

c. Collected only if physicians have the ability to opt-in or opt-out without retribution, penalty, or direct or indirect coercion;

d. Collected only if physicians are able to provide informed consent prior to data acquisition and use;

e. Collected only if physicians retain the option to opt-out at any time;

f. Used only to ameliorate burnout-inducing working conditions. (New HOD Policy)

2. Any use of physician personal health information or biological data that is retaliatory or that perpetuates unjust biases should be avoided and prohibited. (New HOD Policy)

3. The second directive of Policy D-460.962 be rescinded having been accomplished by this report.

Fiscal Note: Less than $500

REFERENCES

1. Resneck, J. Burnout is a health crisis for doctors—and patients. American Medical Association. 2023 March 9. Accessed 2025 January 15. https://www.ama-assn.org/about/leadership/burnout-health-crisis-doctors-and-patients.
2. American Medical Association. Physician burnout rate spikes to new height. American Medical Association. 2022 September 15. Accessed 2025 January 15. https://www.ama-assn.org/press-center/press-releases/physician-burnout-rate-spikes-new-height.
3. Berg, S. Physician burnout rate drops below 50% for first time in 4 years. American Medical Association. Accessed 2024 July 2. https://www.ama-assn.org/practice-management/physician-health/physician-burnout-rate-drops-below-50-first-time-4-years.
4. Berg, S. How these health systems are reducing physician burnout. American Medical Association. 2024 March 7. Accessed 2025 January 15 https://www.ama-assn.org/practice-management/physician-health/how-these-health-systems-are-reducing-physician-burnout.
5. Guille, C., & Sen, S. Burnout, depression, and diminished well-being among physicians. *N Engl J Med*. 2024;391:1519-1527. https://doi.org/10.1056/NEJMra2302878.
6. Adler DA, Tseng E, Moon KC, Young JQ, Kane JM, Moss E, Mohr DC, Choudhury T. Burnout and the quantified workplace: Tensions around personal sensing interventions for stress in resident physicians. *Proceedings of the ACM on Human-computer Interaction*. 2022;6(CSCW2):1-48.
7. Guille C, Sen S. Burnout, depression, and diminished well-being among physicians. *New England J Med*. 2024 Oct 24;391(16):1519-27.
8. Listopad IW, Michaelsen MM, Werdecker L, Esch T. Bio-psycho-socio-Spirito-cultural factors of burnout: a systematic narrative review of the literature. *Frontiers in Psychology*. 2021;12:722862.
9. Goldfield N, Gnani S, Majeed A. Primary care in the United States Profiling performance in primary care in the United. *BMJ.* 2003;326:744–7.
10. Olson K, Marchalik D, Farley H, Dean SM, Lawrence EC, Hamidi MS, Rowe S, McCool JM, O'Donovan CA, Micek MA, Stewart MT. Organizational strategies to reduce physician burnout and improve professional fulfillment. *Current Problems in Pediatric and Adolescent Health Care.* 2019;49(12):100664.
11. American Medical Association. Opinion 1.1.3 Patient rights. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.
12. American Medical Association. Opinion 1.1.6 Quality. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/quality.
13. American Medical Association. Opinion 2.1.1 Informed consent. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent.
14. American Medical Association. Opinion 3.1.1 Privacy in health care. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/privacy-health-care.
15. American Medical Association. Opinion 3.3.4 Research handling of de-identified patient data. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/research-handling-de-identified-patient-data.
16. American Medical Association. Opinion 8.13 Physician competence, self-assessment and self-awareness. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-competence-self-assessment-self-awareness.
17. American Medical Association. Opinion 9.3.1 Physician health and wellness. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-health-wellness.

18. American Medical Association. Opinion 9.3.2 Physician responsibilities to colleague with illness, disability or impairment. *AMA Code of Medical Ethics*. Accessed 2025 January 15. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-responsibilities-colleagues-illness-disability-or-impairment.
19. American Medical Association. AMA Privacy Principles. American Medical Association. 2020 February 7. Accessed January 15. https://www.ama-assn.org/system/files/2020-05/privacy-principles.pdf.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-25

Subject: Bylaws Review Report

Presented by: Jerry Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

Per AMA Bylaw 6.1.1, the Council on Constitution and Bylaws is responsible for recommending changes in the Bylaws as it deems appropriate for action by the House of Delegates. The Council focuses its fact-finding review and proposed bylaw amendments on provisions that are internally inconsistent, incomplete or inaccurate.

In this report, the Council notes that the Bylaw language associated with the process of filling a Medical Student Trustee position is not only inconsistent with language regarding the initial election of the Medical Student Trustee but inconsistent with language about filling other Board vacancies. Also, the Council finds that other language is inaccurate in describing how the medical student members of Councils are appointed and incomplete as to how and when student vacancies may be filled.

The Council has proposed some bylaw amendments to provide consistency, clarity and accuracy.

BACKGROUND

Bylaw 3.5.6 and its subprovisions provide for the election of the Medical Student Trustee by the Medical Student Section and detail the position's term, ability for reelection and the filling of vacancies as follows:

> 3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.
>
> 3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.
>
> 3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.
>
> 3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student

trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program during their term, the trustee shall be permitted to continue to serve on the Board of Trustees for up to 200 days after graduation but not extending past the Annual Meeting following graduation.

Bylaw 3.6 sets forth the process for filling any vacancy on the Board, including that of the Medical Student Trustee:

3.6 Vacancies.

3.6.1 Appointment. The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee shall be filled by appointment by the Board of Trustees from 2 or more nominations provided by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

The Council notes that the filling of some but not all Board vacancies is permissive rather than mandatory, and supports consistent language throughout.

The Council also found that there is inconsistent language across the AMA Councils with respect to appointed members. AMA Policy G-610.090 speaks to the need to make "every effort to have two or more candidates for each vacancy." Policy also directs the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity. The Council supports consistency between the Bylaws and policy.

Furthermore, the Council notes that there is explicit bylaw language regarding the role of the Medical Student Section (MSS) Governing Council vis-a-vis the appointed student members of the AMA Councils. However, the Council, including the Speakers, know it is ultimately the Board's responsibility to make all appointments and believes the Bylaw language should be accurate. Conversely, the Bylaws do not address the role of the Resident and Fellow Section in submitting the names of potential candidates for various appointed Councils as the Board considers not only those physicians nominated by the Resident and Fellow Section, but other residents/fellows who are self-nominated or nominated by a Federation entity.

Lastly, the Council also believes that there should be consistent language across the Councils to permit the Board to fill a vacancy in the medical student position, with the lone exception of the Council on Ethical and Judicial Affairs which does not permit any vacancy to be filled by appointment.

6.5 Council on Ethical and Judicial Affairs.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to

the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

6.5.6 Nomination and Election. The members of the Council shall be elected by the House of Delegates on nomination by the President-Elect who assumes the office of President at the conclusion of the meeting. State associations, national medical specialty societies, Sections, and other organizations represented in the House of Delegates, and members of the Board of Trustees may submit the names and qualifications of candidates for consideration by the President-Elect.

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6.5.9 Vacancies.

6.5.9.1 Members other than the Resident/Fellow Physician Member. Any vacancy among the members of the Council other than the resident/fellow physician member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2-year term.

6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, 2 members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member appointed shall be a medical student member appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

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6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a 4-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2-year term.

6.7 Council on Legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student. These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed from nominations submitted by the Medical Student Section.

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6.7.5 Vacancies. Any vacancy occurring on the Council shall be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

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

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of these Councils other than the

resident/fellow physician and medical student member shall be elected for terms of 4 years.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to /be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

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6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2-year term.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

3--Officers

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3.6 Vacancies.

3.6.1 Appointment. The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee ~~shall~~ may be filled by appointment by the Board of Trustees from a minimum of two ~~2 or more nominations~~ nominees submitted ~~provided~~ by the Medical Student

Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6--Councils

6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, ~~2~~ two members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member ~~appointed~~ shall be a medical student member-appointed by the Board of Trustees from a minimum of two-nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician member and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a ~~4~~four-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a ~~2~~two-year term.

6.6.5.3 Medical Student Member. If the medical student member of the Council ceases to complete the term for which appointed, the Board of Trustees may appoint a successor to fill the remainder of the unexpired term from a minimum of two nominees submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7 Council on Legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student. These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed by the Board of Trustees from a minimum of two nominees ~~nominations~~ submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7.3 Term.

6.7.3.1 Members of the Council on Legislation shall be appointed for terms of one year, beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

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6.7.5 Vacancies. Any vacancy occurring on the Council ~~shall~~ may be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

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

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointments.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than ~~8~~eight years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting with the exception of a medical student who is appointed to fill a vacancy.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a ~~4~~four-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils cease~~s~~ to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a ~~2~~two-year term.

6.9.3.3 Medical Student Member. If the medical student member of these Councils ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician member of a Council who completes residency or fellowship within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. A medical student member of a Council who graduates from an educational program during their term shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-25

Subject: Concurrent Service on Councils and Section Governing Councils

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

Our AMA's parliamentary authority, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC), states that no member can hold two incompatible offices, and recommends that if it is unclear whether certain offices are incompatible, an organization should clarify the compatibility or lack thereof in its bylaws. Per AIPSC (2nd ed.) 26.26, "Incompatibility not only consists of practical impossibility to perform the duties of both offices but also includes a conflict between the duties of the two offices." AIPSC (2nd ed.) further clarifies that unless the bylaws provide otherwise, a member who holds an office may be a candidate for another office without first giving up the current office, but if the member is elected to and accepts an incompatible office, the former office is forfeited. The Council, as part of its responsibilities embodied in Bylaw 6.1.1, examined the AMA Bylaws, Council rules and section Internal Operating Procedures for existing language regarding concurrent service.

AMA Bylaw 3.2.1.1 states, "Trustees shall resign all other positions held by them in the AMA upon their election and/or appointment," with a few exceptions: 1) The Speaker and Vice Speaker, under Bylaw 6.1.2.2, are ex officio members of the Council on Constitution and Bylaws without the right to vote, and 2) the House of Delegates' Selection Committee for the Public Member of the Board of Trustees (Bylaw 2.15.5) includes two appointed trustees; and 3) Bylaws 2.13.6 whereby the membership of Special Committees of the House of Delegates are in accordance with the motions authorizing their appointment and ***may*** include Board members. The Council recognizes that there also are several task forces or committees in which Board and/or Council members have a role, notably the AMA Foundation Board, Search Committee for the AMA Executive Vice President, Task Force on Digital Health and AI, and Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted. The Council also knows that each AMA Council, each AMA Section and the AMPAC Board has one or more trustees who are designated as Board liaisons.

AMA Bylaw 6.5.1.1 states, "No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy." Beyond that, the AMA Bylaws are silent on concurrent service on more than one Council or Section Governing Councils or concurrent service on an AMA Council and a Section Governing Council. While rare, there have been instances over the years where concurrent service has occurred.

The Council found that some but not all Sections have language in their Rules (known as Internal Operating Procedures) prohibiting concurrent service on a Section Governing Council and an AMA Council.

To bring our AMA Bylaws into compliance with AIPSC (2nd ed.), the Council believes it is appropriate that there be AMA Bylaw language specifically prohibiting concurrent service as a voting member on multiple Councils, multiple Section Governing Councils or on a Council and a Section Governing Council. Codifying such language is especially important since most Councils and Section Governing Councils meet in conjunction with the HOD meetings. Council/Section meetings often overlap, as do member responsibilities. Lastly, the Council believes such an explicit prohibition in our AMA Bylaws will eliminate potential conflicts of interest that can occur when holding two leadership positions simultaneously, provide consistency across Councils, and expand a finite number of leadership opportunities to more members.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

6 Councils

6.0.1 Responsibilities

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6.0.1.4 Concurrent Service. A Council member may not serve concurrently as a voting member of more than one Council or on a Council and a Section Governing Council.

7 Sections

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-A-25

Subject: Clarifying Bylaw Language

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Council on Constitution and Bylaws has responsibility per AMA Bylaw 6.1.1 for recommending changes in the Bylaws as it deems appropriate for action by the House of Delegates. In this report, the Council focuses its fact-finding review and proposed bylaw amendments on various provisions relating to membership and representation that are no longer accurate or relevant.

BACKGROUND

Membership Categories (Bylaw Section 1). Our AMA Constitution Article III states, "The American Medical Association is composed of physician members who are represented in the House of Delegates through state associations and other constituent associations, national medical specialty societies and other entities, as specified in the Bylaws." The Bylaws further define constituent associations as "recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America."

The Council is aware that current Bylaw language may be confusing as AMA members are defined by how they pay their dues. At one time, some but not all constituent medical societies sent a single dues invoice to physicians and medical students for dues associated with the constituent medical society, the county medical society and AMA, and the constituent society subsequently transmitted the AMA dues to the AMA along with a list of their AMA dues-paying and dues-exempt members. Those who joined via this mechanism were known as Active Constituent Members. Those physicians and medical students who paid their dues directly to the AMA were categorized as Active Direct Members.

Additional language identifies the other categories of membership (Affiliate Members, Honorary Members and International Members) and specifies the rights and privileges of those members. The Council noted that while these membership categories comprehensively define the rights and privileges of members, the current language for Active and Direct Members does not, and provides only for receipt of the *Journal of the American Medical Association* and such other publications as the Board of Trustees may authorize.

Lastly, the Constitution Article VIII states that "Funds may be raised by annual dues or by assessment on the active members of the Association on recommendation by the Board of Trustees and after approval by the House of Delegates." Bylaw 1.1.1.5 states that active members are liable for such dues as are determined and fixed by the House of Delegates, and Bylaw 1.1.1.5.4 states that "active members are delinquent if their dues and assessments are not received by the House of Delegates." The Council notes the latter is inaccurate as it is the Board of Trustees, not the House of Delegates, which establishes the dues delinquency date.

House of Delegates (Bylaw Section 2). This section identifies the types of entities represented in the HOD, and sets forth the apportionment of the constituent medical societies and the national medical specialty societies. The Bylaws for constituent medical societies and the national medical specialty societies grant an extra delegate to those societies that are 'unified' (require all its members to also be AMA members). The Council learned that there have been no unified societies since 2007.

Another bylaw awards an additional delegate to those constituent societies who are not unified but where 75 percent or more of their members are AMA members. The Council learned that it has been many years since any constituent society had such a large percentage of AMA members.

Young Physicians Section (Bylaws Section 7.5) Similarly, in Section 7, unified societies receive additional delegates to the Young Physicians Section.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

1—Membership

1.1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active ~~Constituent, Active Direct,~~ Members, Affiliate Members, Honorary Members, and International Members.

1.1.1 Active Member~~ship~~.

~~**1.1.1.1 Active Constituent.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:~~

~~a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.~~

~~b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.~~

~~1.1.1.1.1 **Admission.** Active constituent members are admitted to membership upon certification by the constituent association to the AMA, provided there is no disapproval by the Council on Ethical and Judicial Affairs.~~

1.1.1.1 Active Members.

~~1.1.1.1 **Active Direct.** Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have been granted representation in the House of Delegates.~~

Active ~~direct~~ members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.1.1

~~1.1.1.2.1~~ **Admission.** Active ~~direct~~ members are admitted to membership upon application to the AMA or through a constituent association, provided that there is no disapproval by the Council on Ethical and Judicial Affairs or an objection to membership from a society represented in the House of Delegates.

1.1.1.1.1.1

~~1.1.1.2.1.1~~ **Notice.** The AMA shall notify each constituent association of the name and address of those applicants for ~~active direct~~ membership residing within its jurisdiction.

1.1.1.1.1.2

~~1.1.1.2.1.2 **Objections.** Objections to applicants for active direct membership must be received by the Executive Vice President of the AMA within 45 days of receipt by the constituent association of the notice of the application for such membership.~~ All objections to membership will immediately be referred to the Council on Ethical and Judicial Affairs for prompt disposition

pursuant to the rules of the Council on Ethical and Judicial Affairs.

1.1.1.2
~~1.1.1.3~~ **Council on Ethical and Judicial Affairs Review.** The Council on Ethical and Judicial Affairs may consider information pertaining to the character, ethics, professional status and professional activities of the applicant for membership. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.1.1.3
~~1.1.1.4~~ **Rights and Privileges.** Active members may attend AMA meetings, hold office, and are entitled to receive the *Journal of the American Medical Association* and such other publications as the Board of Trustees may authorize.

1.1.1.4
~~1.1.1.5~~ **Dues and Assessments.** Active members are liable for such dues and assessments as are determined and fixed by the House of Delegates.

~~1.1.1.5.1 **Active Constituent Members.** Active constituent members shall pay their annual dues to the constituent associations for transmittal to the AMA, except as may be otherwise arranged by the Board of Trustees.~~

~~1.1.1.5.2 **Active Direct Members.** Active direct members shall pay their annual dues directly to the AMA.~~

1.1.1.4.1
~~1.1.1.5.3~~ **Exemptions.** On request, active members may be exempt from the payment of dues on January 1 following their sixty-fifth birthday, provided they are fully retired from the practice of medicine. Additionally, the Board of Trustees may exempt members from payment of dues to alleviate financial hardship or because of retirement from medical practice due to medical disability. The Board of Trustees shall establish appropriate standards and procedures for granting all dues exemptions. Members who were exempt from payment of dues based on age and retirement under Bylaw provisions applicable in prior years shall be entitled to maintain their dues-exempt status in all subsequent years. Dues exemptions for financial hardship or medical disability shall be reviewed annually.

1.1.1.4.2
~~1.1.1.5.4~~ **Delinquency.** Active members are delinquent if their dues and assessments are not received by the date determined by the Board of Trustees ~~House of Delegates~~, and shall forfeit their membership in the AMA if such delinquent dues and assessments are not received by the AMA within

30 days after a notification to the delinquent member has been made on or following the delinquency date.

1.1.2 Affiliate Members.

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1.1.3 Honorary Members.

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1.1.4 International Members.

Physicians who have graduated from medical schools located outside the United States and its territories and are ineligible to be ~~for~~ Active Members ~~Constituent or Active Direct membership~~ and who can fulfill and document the following requirements:

a. Graduation from a medical school listed in the World Health Organization Directory.

b. Possession of a valid license in good standing in the country of graduation or practice location documented by one of the following:

(i) verification that the applicant is an international member of a national medical specialty society seated in the House of Delegates that has a procedure to verify the applicant's educational credentials;

(ii) certification from the national medical association in the country of practice attesting to the applicant's valid authorization to practice medicine without limitation; or

(iii) certification from the registry or licensing authority of the country of practice attesting to the applicant's valid license in good standing.

1.1.4.1 Admission. International members are admitted to membership by providing a completed application accompanied by the required documentation. The Council on Ethical and Judicial Affairs shall provide by rule for an appropriate hearing procedure to be provided to the applicant should denial of membership be based on information pertaining to the applicant's character, ethical conduct, or professional status.

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1.2 Maintenance of Membership.

A member may hold only one category of membership in the AMA at any one time. Membership may be retained as long as the member complies with the provisions of the Constitution and Bylaws and Principles of Medical Ethics of the AMA.

~~1.3 Transfer of Membership.~~

~~Members of the AMA, except members serving full time in the Federal Services, who move to a jurisdiction in which the constituent association requires that all members of the constituent association be members of the AMA, must apply for membership in the constituent association within one year after moving into the jurisdiction to continue membership in the AMA. Unless membership in the constituent association has been granted within 2 years after application, membership in the AMA shall cease.~~

1.3
~~1.4~~ **Discrimination.**

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

1.4.
~~1.5~~ **Termination of Membership or Other Discipline.**

The Council on Ethical and Judicial Affairs, after due notice and hearing may censure, suspend, expel, or place on probation any member of the AMA for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct.

2—House of Delegates

2.0.1 **Composition and Representation.** The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

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2.1 **Constituent Associations.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment~~, and such additional delegate seats as may be provided under Bylaw 2.1.1.2~~. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 **Apportionment.** The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 **Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

~~**2.1.1.2 Unified Membership.** A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment during the first 2 years in which the unified membership bylaw provisions are implemented.~~

~~**2.1.2 Additional Delegates.** A constituent association meeting the following criteria shall be entitled to the specified number of additional delegates.~~

~~**2.1.2.1 Unified Membership.** A constituent association shall be entitled to 2 additional delegates if all of its members are also members of the AMA. If during any calendar year a constituent association adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the constituent association shall be entitled to the 2 additional delegates. The constituent association shall retain the 2 additional delegates only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that all of the constituent association's members are members of the AMA.~~

~~**2.1.2.2 Minimum 75% Membership.** A constituent association shall be entitled to one additional delegate if 75% or more of its members, but not all of its members, are members of the AMA. The constituent association shall retain the additional delegate only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that 75% or more of the constituent association's members are members of the AMA. If the membership information indicates that less than 75% of the constituent association's members are members of the AMA, the constituent association shall be permitted to retain the additional delegate for one additional year if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. If the membership information for the constituent association, as recorded by the AMA as of the following December 31 indicates that for the second successive year less than 75% of the constituent association's members are members of the AMA, the constituent association shall not be entitled to retain the additional delegate.~~

~~**2.1.2.3 Maximum Additional Delegates.** No constituent association shall be entitled to more than 2 additional delegates under Bylaw 2.1.2.~~

~~2.1.2.3.1 **Effective Date.** The additional delegates provided for under this bylaw shall be based upon membership information recorded by the AMA as of December 31 of each year. Allocation of these seats shall take effect on January 1 of the following year.~~

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment~~, and such additional delegate seat as may be provided under Bylaw 2.2.2~~. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 ~~and 2.1.2~~ using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate for each 1,000, or fraction thereof, physician specialty society members as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA. ~~The delegates eligible for seating in the House of Delegates by apportionment are in addition to the additional delegate and alternate delegate authorized for unified specialty societies meeting the requirements of Bylaw 2.2.2.~~

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

~~2.2.2 **Additional Delegate.** A specialty society that has adopted and implemented bylaw provisions requiring unified membership is entitled to one additional delegate. If during any calendar year the specialty society adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the specialty society shall be entitled to the additional delegate. The specialty society shall retain the additional delegate only if the membership information recorded by the AMA as of each subsequent December 31 confirms that all of the specialty society's members are members of the AMA.~~

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6—Councils

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6.5 Council on Ethical and Judicial Affairs.

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6.5.3 Original Jurisdiction. The Council on Ethical and Judicial Affairs shall have original jurisdiction in:

6.5.3.1 All questions involving membership as provided in Bylaws 1.1.1.1.1, 1.1.4.1 and 1.4 ~~1.1.1.1, 1.1.1.2, 1.1.2, 1.1.4, and 1.5~~.

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7—Sections

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7.5 Young Physicians Section.

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7.5.3 Representatives to the Business Meeting. The Business Meeting shall consist of representatives from constituent associations, Federal Services, and national medical specialty societies represented in the House of Delegates. There shall be no alternate representatives.

7.5.3.1 Constituent Associations, National Medical Specialty Societies, and Federal Services. Each constituent association and Federal Service shall be entitled to representation based on the number of seats allocated to it by apportionment. Each national medical specialty society granted representation in the House of Delegates shall be entitled to representation based on the number of seats allocated to it by apportionment. ~~In addition, unified constituent associations and specialty societies that are entitled to additional representation pursuant to Bylaw 2.1.1.2 or Bylaw 2.2.1 shall be entitled to 2 additional representatives.~~

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-25

Subject: The AMA *Code of Medical Ethics* Evolving to Provide Health Care Systems Ethics Guidance

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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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

REFERENCES

1. Ethics. American Medical Association. February 21, 2025. Accessed February 21, 2025. https://www.ama-assn.org/delivering-care/ethics
2. Code of Medical Ethics. *AMA Code of Medical Ethics*. Accessed February 21, 2025. https://code-medical-ethics.ama-assn.org/.
3. American Medical Association. History of the Code. 2017.
4. Brotherton S, Kao A, Crigger BJ. Professing the Values of Medicine: The Modernized AMA Code of Medical Ethics. *JAMA*. 2016;316(10):1041. doi:10.1001/jama.2016.9752
5. Kane CK. Policy Research Perspectives. American Medical Association. Published online 2023.
6. AMA analysis shows most physicians work outside of private practice. American Medical Association. May 5, 2021. Accessed February 26, 2025. https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice.

REPORT 02 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization (Res 016-A-23)

EXECUTIVE SUMMARY

In adopting Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," the House of Delegates requested 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."

Although not all collective actions by physicians may impact clinical practice, 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 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. To respond to these issues, CEJA recommends amending Opinion 1.2.10, "Political Action by Physicians," to more clearly articulate that 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 to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions should, though, only be undertaken as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-25

Subject: Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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.

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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:

1. 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:

(a) ~~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.

(b) ~~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.

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

(d) 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.

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

(f) 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.

(g) 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.

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

Fiscal Note: Less than $500

REFERENCES

1. Bowling D, Richman BD, Schulman KA. The rise and potential of physician unions. JAMA 2022;328(7):617-8.
2. AMA. Issue brief: Collective bargaining for physicians and physicians-in-training. AMA Advocacy Resource Center 2023. https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf.
3. Scheiber N. Why Doctors and Pharmacists Are in Revolt. NY Times 3 December 2023. https://www.nytimes.com/2023/12/03/business/economy/doctors-pharmacists-labor-unions.html?unlocked_article_code=1.DE0.ct8T.5mKAmg0HXEfX&hpgrp=ar-abar&smid=url-share.
4. Richman BD, Schulman KA. Restoring Physician Authority in an Era of Hospital Dominance. JAMA 2022;328(24):2400-1.
5. Burroughs J. Re-design the Medical Staff Model. Chicago: American College of Healthcare Executives, 2015: 1-22; Gosfield AG. The organized medical staff: should anyone care anymore? J Med Pract Manage. 2005 Jan-Feb;20(4):210-6.
6. Thompson SL, Salmon JW. Strikes by physicians: a historical perspective toward an ethical evaluation. Int J of Health Serv 2006;36(2):331-54.
7. Zhu JM, Rooke-Ley H, Fuse Brown E. A Doctrine in Name Only - Strengthening Prohibitions against the Corporate Practice of Medicine. N Engl J Med. 2023 Sep 14;389(11):965-968.
8. American Medical Association. H-385.973 Collective Negotiations. Accessed May 13, 2024. https://policysearch.ama-assn.org/policyfinder/detail/H-385.973?uri=%2FAMADoc%2FHOD.xml-0-3292.xml.
9. American Medical Association. H-385.976 Physician Collective Bargaining. Accessed May 13, 2024 https://policysearch.ama-assn.org/policyfinder/detail/H-385.976?uri=%2FAMADoc%2FHOD.xml-0-3294.xml.
10. American Medical Association. Opinion 1.1.3 Patient Rights. Code of Medical Ethics. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.
11. American Medical Association. Opinion 1.1.6 Quality. Code of Medical Ethics. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.
12. American Medical Association. Opinion 9.3.1 Physician Health and Wellness. Code of Medical Ethics. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-health-wellness.
13. WMA statement on the ethical implications of collective actions by physicians. WMA 2022. https://www.wma.net/policies-post/wma-statement-on-the-ethical-implications-of-collective-action-by-physicians/#:~:text=The%20World%20Medical%20Association%20recommends,or%20professional%20obligations%20to%20patients.
14. Zwolinski M, Ferguson B, Wertheimer A. Exploitation. The Stanford Ency of Phil, Edward N. Zalta & Uri Nodelman, eds. 2022;Winter. https://plato.stanford.edu/archives/win2022/entries/exploitation/.
15. Vesoulis A. ‘I’m mentally and physically exhausted.’ Healthcare workers battling coronavirus are running out of protective gear. Time. Published March 24, 2020. https://time.com/5808992/healthcare-workers-lack-ppe/.

16. Working overtime, not seeing family members for days, doctors recount struggle during covid fight. The Economic Times. Published July 1, 2021. https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/working-overtime-not-seeing-family-members-for-days-doctors-recount-struggle-during-covid-fight/articleshow/84037386.cms?from=mdr.
17. Iacobucci G. Covid-19: Doctors feel under pressure to work extra shifts unpaid, survey shows. BMJ 2021;373:n1189. doi:10.1136/bmj.n1189.
18. Howard D. What should physicians consider prior to unionizing? AMA JoE 2020;22(3):193-200.
19. Thompson SL, Salmon JW. Physician strikes. Chest 2014;146(5):1369-1374. doi:10.1378/chest.13-2024.
20. Jackson RL. Physician strikes and trust. Cambridge Quarterly of Healthcare Ethics 2000;9(4):504-12.
21. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J of Int Med 2018;283(6):516-29.
22. Pellegrino ED, Relman AS. Professional medical associations: ethical and practical guidelines. JAMA 1999;282:984; Pellegrino ED Humanism and the Physician. Knoxville: University of Tennessee Press, 1979:122.
23. Cohen JJ. White coats should not have union labels. N Engl J Med. 2000 Feb 10;342(6):431-4. doi: 10.1056/NEJM200002103420614.
24. Bion J. Are doctors justified in taking industrial action in defense of their pensions? No. BMJ 2012;344:e3175; Glick SM. Health workers' strikes: a further rejoinder. J Med Ethics 1986;12:43-44.
25. Cunningham SA, Mitchell K, Narayan KV, Yusuf S. Doctors' strikes and mortality: a review. Soc Sci & Med 2008;67(11):1784-8.
26. Essex R, Milligan W, Williams G, Weldon SM. The impact of strike action on patient morbidity: A systematic literature review. The Int J of Health Plan and Manag 2022;37(3):1311-26.
27. Essex R, Weldon SM, Thompson T, Kalocsányiová E, McCrone P, Deb S. The impact of health care strikes on patient mortality: A systematic review and meta-analysis of observational studies. Health Serv Res 2022;57(6):1218-34.
28. Stoye G, Warner M. The effects of doctor strikes on patient outcomes: Evidence from the English NHS. J of Econ Behav & Org 2023;212:689-707.
29. Young JY. More doctors walk off the job in Korea. New York Times. June 18, 2024: https://www.nytimes.com/2024/06/18/world/asia/south-korea-doctor-strike.html.
30. Goold SD. Collective action by physicians: beyond strikes. Camb Q Healthc Ethics. 2000 Fall;9(4):498-503. doi: 10.1017/s0963180100904079.

REPORT 05 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
"Protecting Physicians Who Engage in Contracts to Deliver Health Care Services"
(D-140.951)

EXECUTIVE SUMMARY

Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," asks that the Council on Ethical and Judicial Affairs (CEJA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership".

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. The ethical concerns raised by private equity firms' incursion into health care warrant extreme caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services" to more clearly encompass partnerships with private equity firms and the ethical dilemmas and obligations that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned health care entities.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-25

Subject: Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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

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:

(a) 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.

(b) 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:

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

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

(e) 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.

(f) 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:

(g) 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.

1 (Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REFERENCES

1. Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. *Stanford Law Review*. 2024;76.
2. Crowley R, Atiq O, Hilden D, Health and Public Policy Committee of the American College of Physicians. Financial profit in medicine: A position paper from the American College of Physicians. *Annals of Internal Medicine*. 2021;174(10):1447-9.
3. Moses MJ, Weiser LG, Bosco III JA. The corporate practice of medicine: Ethical implications of orthopaedic surgery practice ownership by non-physicians. *JBJS*. 2020;102(11):e53.
4. AMA analysis shows most physicians work outside of private practice. In: American Medical Association. https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice#:~:text=Employment%20status,2018%20and%2053.2%25%20in%202012.
5. Gondi S, Song Z. Potential implications of private equity investments in health care delivery. JAMA 2019;321(11):1047-8.
6. Zhu JM, Polsky D. Private equity and physician medical practices-navigating a changing ecosystem. *NEJM.* 2021;384(11):981-3.
7. Ikram U, Aung KK, Song Z. Private equity and primary care: Lessons from the field. *NEJM Catalyst Innovations in Care Delivery*. 2021;2(6).
8. DeCamp M, Snyder Sulmasy L, American College of Physicians Ethics, Professionalism and Human Rights Committee. Ethical and professionalism implications of physician employment and health care business practices: a policy paper from the American College of Physicians. *Ann of Intern Med*. 2021;174(6):844-51.
9. Appelbaum E, Batt R. Private equity buyouts in healthcare: who wins, who loses? Institute for New Economic Thinking Working Paper Series 2020(118). doi.org/10.36687/inetwp118.
10. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ*. 2023;382.
11. Bhatla A, Bartlett VL, Liu M, Zheng Z, Wadhera RK. Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals. *JAMA*. 2025;333(6):490–497. doi:10.1001/jama.2024.23450
12. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365-2375. doi:10.1001/jama.2023.23147
13. Singh Y, Radhakrishnan N, Adler L, Whaley C. Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications. *JAMA Health Forum*. 2025;6(1):e244935. doi:10.1001/jamahealthforum.2024.4935
14. PESP Private Equity Hospital tracker. In: *Private Equity Stakeholder Project PESP*. https://pestakeholder.org/private-equity-hospital-tracker/.
15. New 12: FTC Announces Rule Banning Noncompetes. *FTC*. 23 April 2024. https://www.ftc.gov/news-events/news/press-releases/2024/04/ftc-announces-rule-banning-noncompetes
16. Levinson Z, Hulver S, Neuman T. Hospital charity care: how it works and why it matters. KFF 2022 Nov 3. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/.
17. 2024 fair share spending report: Are hospitals giving back as much as they take? Lown Institute, 2024 Hospitals Index. https://lownhospitalsindex.org/hospital-fair-share-spending-2024/.
18. Scott D. A worrisome trend in American hospitals is hurting poor patients. *Vox*. 2023 Jan 13. https://www.vox.com/policy-and-politics/2023/1/13/23550067/us-hospitals-medicaid-patients-health-care-access.

19. Veatch RM. Ethical dilemmas of for-profit enterprise in health care. In *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment.* Gray BH, ed. National Academy Press, Washington DC, 1983.
20. Pellegrino ED. The commodification of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic. *J Med Philos*. 1999;24(3):243-266. doi:10.1076/jmep.24.3.243.2523.
21. Powers BW, Shrank WH, Navathe AS. Private equity and health care delivery: value-based payment as a guardrail?. *JAMA*. 2021;326(10):907-8.
22. Cox C, Ortaliza J, Wager E, Amin K. Health care costs and affordability. KFF 2024 May 28. https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction.
23. Whitehouse S, Grassley CE. Profits over patients: The harmful effects of private equity on the U.S. health care system. Senate Budget Committee Bipartisan Staff Report. January 2025. https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 06-A-25

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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"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 responsibilit~~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.
>
> ~~(a) 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.~~

~~(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~

(c) ~~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

REFERENCES

1. American Medical Association. H-165.837: Protecting the Patient-Physician Relationship. Accessed April 1, 2024. https://policysearch.ama-assn.org/policyfinder/detail/patient-physician%20relationship?uri=%2FAMADoc%2FHOD.xml-0-823.xml
2. American Medical Association. H-225.950: AMA Principles for Physician Employment. Accessed April 1, 2024. https://policysearch.ama-assn.org/policyfinder/detail/patient-physician%20relationship?uri=%2FAMADoc%2FHOD.xml-0-1535.xml
3. American Medical Association. H-275.937: Patient/Physician Relationship and Medical Licensing Boards. Accessed April 1, 2024. https://policysearch.ama-assn.org/policyfinder/detail/patient-physician%20relationship?uri=%2FAMADoc%2FHOD.xml-0-1915.xml
4. American Medical Association. Opinion 1.1.1 Patient-Physician Relationship. *Code of Medical Ethics.* Accessed April 1, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships
5. American Medical Association. Opinion 1.1.3 Patient Rights. *Code of Medical Ethics.* Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights
6. American Medical Association. Opinion 1.1.5 Terminating a Patient-Physician Relationship. *Code of Medical Ethics.* Accessed April 1, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/terminating-patient-physician-relationship
7. American Medical Association. Opinion 1.1.6 Quality. *Code of Medical Ethics.* Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/quality
8. American Medical Association. Opinion 1.1.7 Physician Exercise of Conscience. *Code of Medical Ethics.* Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience
9. American Medical Association. Opinion 8.6 Promoting Patient Safety. *Code of Medical Ethics.* Accessed April 1, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/promoting-patient-safety
10. Pellegrino, E. Toward a Reconstruction of Medical Morality. *AJOB.* 2006; 6(2): 65-71.
11. Simpson JA. Foundations of interpersonal trust. In Kruglanski A, Higgins ET eds. *Social Psychology*. New York: The Gilford Press; 2007: 587-607.
12. Pellegrini CA. Trust: the keystone of the patient-physician relationship. *J of the Am College of Surgeons.* 2017;224(2):95-102.
13. Khullar D. Building trust in health care—why, where, and how. *JAMA*. 2019 Aug 13;322(6):507-9.
14. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient–physician relationship. *Journal of General Internal Medicine*. 1999;14(Suppl 1):S34.
15. Roter D. The enduring and evolving nature of the patient–physician relationship. *Patient Education and Counseling*. 2000;39(1):5-15.
16. Berger R, Bulmash B, Drori N, Ben-Assuli O, Herstein R. The patient–physician relationship: an account of the physician's perspective. *Israel Journal of Health Policy Research*. 2020;9:1-6.
17. Clever SL, Jin L, Levinson W, Meltzer DO. Does doctor–patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable. *Health Services Research*. 2008;43(5p1):1505-19.
18. Shirley ED, Sanders JO. Patient satisfaction: implications and predictors of success. *JBJS*. 2013;95(10):e69.
19. Linzer M, Neprash H, Brown R, Williams E, Audi C, Poplau S, Prasad K, Khullar D, Healthy Work Place Investigators. Where trust flourishes: perceptions of clinicians who trust their organizations and are trusted by their patients. *The Annals of Family Medicine.* 2021;19(6):521-6.

20. Zhang X, Li L, Zhang Q, Le LH, Wu Y. Physician empathy in doctor-patient communication: A systematic review. *Health Communication*. 2023:1-11.
21. Sandy LG, Pham HH, Levine S. Building trust between physicians, hospitals, and payers: a renewed opportunity for transforming US health care. *JAMA*. 2019;321(10):933-4.
22. Honavar SG. Patient–physician relationship–Communication is the key. *Indian journal of ophthalmology*. 2018;66(11):1527-8.

REPORT 07 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
Guidelines on Chaperones for Sensitive Exams
(Reference Committee on Ethics and Bylaw)

EXECUTIVE SUMMARY

In this report, CEJA considers the appropriate use of chaperones for sensitive exams, and, in general, how to create safe environments for all patients while maintaining professional boundaries. The report recommends revising Opinion 1.2.4, "Use of Chaperones" to reflect current best practices for sensitive exams. New recommendations include: (1) adoption of an "opt-out" approach for sensitive exams in routine circumstances; (2) the requirement of training/qualifications for chaperones; (3) guidance for when a physician may require a chaperone even if the patient declines; and (4) guidance for sensitive examinations and persons who cannot give informed consent, including children and adolescents.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 07-A-25

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaw

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:
>
> a. Opt-out chaperones for breast, genital, and rectal exams.
> b. Documentation surrounding the use or not-use of chaperones.
> c. Use of chaperones for patients without capacity.
> d. Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
> e. 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

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

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

REFERENCES

1. American College of Obstetricians and Gynecologists. ACOG Committee Opinion: Sexual Misconduct. *Obstetrics and Gynecology*. 2020; 135 (1), e43-e49.
2. University of Michigan. The Use of Chaperones During Sensitive Examinations. uofmhealth.org. https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures, Published April 28, 2020, Accessed February 9, 2023.
3. Best Practices for Sensitive Exams. Acha.org www.acha.org/documents/resources/guidelines/ACHA_Best_Practices_for_Sensitive_Exams_October2019.pdf. Published October 2019, Accessed February 2, 2023.
4. Pimienta AL, Giblon RE. The Case for Medical Chaperones. *Fam Pract Manag.* 2018;25(5):6-8.
5. Ginwright S. The Future of Healing: Shifting From Trauma Informed Care to Healing Centered Engagement. Medium. May 31, 2018. https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c. Accessed August 5, 2024.
6. Tillman, S. Consent in Pelvic Care. *Journal of Midwifery & Women's Health.* Nov/Dec 2020; 65(6): 749-758.
7. Klein, D, Paradise, S, and Goodwin T. Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know. *American Family Physician.* 2018; 98(11): 645-653.
8. Association of Women's Health, Obstetric and Neonatal Nurses. Position Statement: The Use of Chaperones during Sensitive Examinations and Treatments. *JOGNN*. March 2022; 51(2):e1-e2.
9. Vogel L. Chaperones: friend or foe? *CMAJ* 2012; 184(6): 642-643.
10. Whitford D, Karim M and Thompson, G. Attitudes of patients towards the use of chaperones in primary care. *British Journal of General Practice*. May 2001: 381-383.
11. Segal J. When Seeing Patients, is Three a Crowd? Medicaljustice.com. https://medicaljustice.com/seeing-patients-three-crowd/ Published December 2, 2015, Accessed February 9, 2023.
12. Morgan R, et al. Thanks for asking: Adolescent attitudes and preferences regarding use of chaperones during physical examinations. *Paediatr Child Health*. 2016; (21, 4): 191-195.
13. Mackay D. Opt-out and consent. *J Med Ethics* 2015; 41:832-835.
14. Chaperones. *Medical Protection*. July 12, 2018. https://www.medicalprotection.org/uk/articles/chaperones. Accessed December 17, 2024.
15. American Academy of Pediatrics. Policy Statement-Use of Chaperones During Physical Examination of the Pediatric Patient. *Pediatrics.* 2011; 127(5): 991-993.
16. Feldman KW et al. Toward instituting a chaperone policy in outpatient pediatric clinics. *Child Abuse & Neglect*. 2009. 33: 709-716.
17. American Medical Association Council on Ethical and Judicial Affairs. CEJA Report 10-A-98: Use of Chaperones during Physical Exams. 1998. https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/1.2.4%20Use%20of%20chaperones%20--%20background%20reports_0.pdf Accessed Feb. 14, 2023.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 08-A-25

Subject:	Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
Presented by:	Jeremy A. Lazarus, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

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].

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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:

(a) Make efforts to increase the supply of organs for transplantation.

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

(c) 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

REFERENCES

1. Lee BP, Terault NA, Liver Transplantation in Unauthorized Immigrants in the United States. *Hepatology.* 2020;71(5):1802-1812.
2. Council on Ethical and Judicial Affairs. Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients. *Arch Intern Med.* 1995;155:29-40.
3. Baru JS, Lucas BR, Martinez C, Brauner D. Organ Donation Among Undocumented Hispanic Immigrants: An Assessment of Knowledge and Attitudes. *J Clin Ethics.* 2013;24(4):364-372.
4. Ackah RL, Sigireddi RR, Murthy BVR. Is Organ Retransplantation Among Undocumented Immigrants in the United States Just? *AMA Journal of Ethics.* 2019;21(1):E17-25.
5. Harwood D, Bediako H. Does Our Organ Transplant System Exploit Undocumented Immigrants? *Bioethics Today*. Published: May 18, 2023.
6. Organ Procurement Transplantation Network Policies. *OPTN.* Effective Date: September 28, 2023.
7. Maier S. Undocumented Immigrants' Transplant Survival Rates on Par with U.S. Citizens'. *UC San Francisco*. September 20, 2019.
8. Sinnenberg L, Machado SR, et al. Citizenship Status and Cardiothoracic Organ Transplantation in the United States. *Circulation: Heart Failure*. 2020;13:780-782.
9. Grubbs V. Undocumented Immigrants and Kidney Transplant: Costs and Controversy. *Health Affairs.* February 2014;33(2):332-335.
10. Goldstein J. Why Undocumented Immigrants Struggle to Receive Organ Transplants. *New York Times.* Published: May 16, 2023.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 09-A-25

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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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].

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 [12]. 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" [13]. 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 [14]. 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

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

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.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

REFERENCES

1. Martin JA, Hamilton BE, et al. Births: Final Data for 2007. *National Vital Statistics Reports*. 2010;58(24):1-85.
2. Wesley BD, Sewell CA, et al. Prescription medications for use in pregnancy-perspective from the US Food and Drug Administration. *AJOG.* 2021;225(1):21-32.
3. Center for Drug Evaluation Research and Center for Biologics Evaluation and Research. Pregnant Women: Scientific and Ethical Considerations for Inclusion in Clinical Trials: Guidance for Industry. *Food and Drug Administration*. Published: April 2018. Available at: https://www.fda.gov/media/112195/download?attachment
4. Haire D. FDA Approved Obstetric Drugs: Their Effects on Mother and Baby. New York: American Foundation for Maternal and Child Health, 2001 Available at: https://asanfranciscodoula.com/resources/Preview%20of%20"FDA%20Approved%20Obstetric%20Drugs-%20Their%20Effects%20on%20Mother%20and%20Baby".pdf
5. Lyerly A., Little M, Faden R. The Second Wave: Toward Ethical Inclusion of Pregnant Women in Clinical Research. *International Journal of Feminist Approaches to Bioethics* . 2008; 1(2):5–22.
6. Wilson 2007. SOGC clinical practice guideline #199: Principles of teratology. *Journal of Obstetrics and Gynaecology Canada*. 2007;21(11): 911–917
7. Blehar MC, Spong C, Grady C, Goldkind SF, Sahin L, Clayton JA. Enrolling pregnant women: issues in clinical research. *Womens Health Issues.* 2013 Jan;23(1):e39-45.
8. Friesen P, Gelinas L, Kirby A, Strauss DH, Bierer BE. IRBs and the Protection-Inclusion Dilemma: Finding a Balance. *The American Journal of Bioethics*. 2022;23(6):75–88.
9. Illamola SM, Bucci-Rechtweg C, et al. Inclusion of pregnant and breastfeeding women in research – efforts and initiative. *Br J Clin Pharmacol*. 2018;8:215–222.
10. 45 CFR 46, Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/common-rule-subpart-b/index.html#46.204
11. A Point in Time eCFR System, 45 CFR § 46.107, *National Archives*. 2018. Available at: https://ecfr.gov/compare/2018-07-19/to/2018-07-18/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.107
12. International Ethical Guidelines for Health-related Research Involving Humans. *Council for International Organizations of Medical Sciences (CIOMS)*. Published: 2016. Available at: https://cioms.ch/wp-content/uploads/2017/01/WEB-CIOMS-EthicalGuidelines.pdf
13. Roest J, Nkosi B, et al. Respecting relational agency in the context of vulnerability: What can research ethics learn from the social sciences? *Bioethics.* 2023;37:379-388.
14. Shields KE, Lyerly AD. Exclusion of pregnant women from industry-sponsored clinical trials. *Obstet Gynecol*. 2013:122(5):1077-1081

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 10-A-25

Subject: The Preservation of the Primary Care Relationship

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

REFERENCES

1. Ezeonwu MC. Specialty-care access for community health clinic patients: processes and barriers. J Multidiscip Healthc. 2018;11:109-119. doi: 10.2147/JMDH.S152594. PMID: 29503559; PMCID: PMC5826087. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5826087/
2. AMA president sounds alarm on national physician shortage. AMA Press Release. 2023 Oct 25. https://www.ama-assn.org/press-center/press-releases/ama-president-sounds-alarm-national-physician-shortage
3. State of the Primary Care Workforce, 2023. HRSA Health Worksforce. 2023 Nov. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf
4. Banthin JS, Taylor AK. HMO enrollment in the United States: estimates based on household reports, 1996. US Department of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality. 2001. https://meps.ahrq.gov/data_files/publications/rf15/rf15.shtml#:~:text=Total%20HMO%20Enrollment%20The%20rate%20of%20HMO,group%20of%20whites%20and%20others%20(40.1%20percent)
5. HMO vs. PPO Insurance Plans. Medical Mutual. 2024. https://www.medmutual.com/Individuals-and-Families/HMO-vs-PPO-Insurance-Plans#:~:text=HMOs%20Generally%20Win%20on%20Cost,off%20will%20be%20flexibility%2C%20however

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 11-A-25

Subject: CEJA's Sunset Review of 2015 House Policies

Presented by: Jeremy Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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

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

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

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

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

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

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

RECOMMENDATION

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

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 to Physician Credentialing	1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-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.	Retain; remains relevant.

		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 evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of	Retain; remains relevant.

		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.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[1]

CEJA Report 13-A-25

Subject: Presumed Consent & Mandated Choice for Organs from Deceased Donors

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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:
>
> (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
>
> (b) Has been developed in consultation with the population among whom it is to be carried out.
>
> (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
>
> ~~Unless there are data that suggest a positive effect on donation, 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

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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

REFERENCES

1. Organ Donation Statistics. Health Resources & Services Administration. Accessed February 17, 2025. https://www.organdonor.gov/learn/organ-donation-statistics
2. Morgan SE, Harrison TR, Afifi WA, Long SD, Stephenson MT. In their own words: the reasons why people will (not) sign an organ donor card. *Health Commun*. 2008;23(1):23-33. doi:10.1080/10410230701805158
3. Symons X, Poulden B. An Ethical Defense of a Mandated Choice Consent Procedure for Deceased Organ Donation. *Asian Bioeth Rev*. 2022;14(3):259-270. Published 2022 Apr 29. doi:10.1007/s41649-022-00206-5
4. Molina-Pérez A, Rodríguez-Arias D, Delgado J. Differential impact of opt-in, opt-out policies on deceased organ donation rates: a mixed conceptual and empirical study. *BMJ Open*. 2022;12(9):e057107. doi:10.1136/bmjopen-2021-057107
5. American Medical Association. 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors. https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/6.1.4%20Presumed%20consent%20%26%20mandated%20choice%20for%20organs%20from%20deceased%20donors%20--%20background%20reports.pdf. 2005
6. Arshad A, Anderson B, Sharif A. Comparison of organ donation and transplantation rates between opt-out and opt-in systems. *Kidney International*. 2019;95(6):1453-1460. doi:10.1016/j.kint.2019.01.036
7. Ahmad MU, Hanna A, Mohamed AZ, et al. A Systematic Review of Opt-out Versus Opt-in Consent on Deceased Organ Donation and Transplantation (2006-2016). *World J Surg*. 2019;43(12):3161-3171. doi:10.1007/s00268-019-05118-4
8. Madden S, Collett D, Walton P, et al. The effect on consent rates for deceased organ donation in Wales after the introduction of an opt-out system. *Anaesthesia*. 2020;75(9):1146-1152. doi:10.1111/anae.15055
9. Matesanz R, Domínguez-Gil B. Opt-out legislations: the mysterious viability of the false. *Kidney International*. 2019;95(6):1301-1303. doi:10.1016/j.kint.2019.02.028
10. Etheredge HR. Assessing Global Organ Donation Policies: Opt-In vs Opt-Out. *Risk Manag Healthc Policy*. 2021;14:1985-1998. doi:10.2147/RMHP.S270234.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-25)

Introduced by: Illinois

Subject: Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the International Federation of Medical Student Associations (IFMSA) is a global organization that fosters collaboration, education, and advocacy among medical students from diverse countries; and

Whereas, the IFMSA has suspended the Federation of Israeli Students of Medicine, a member society, based on the perceived political or military policies of its host country; and

Whereas, the Illinois State Medical Society and the American Medical Association uphold principles of equity, inclusion, and the importance of engagement in a diverse global community; and

Whereas, It is essential for medical organizations, including international medical organizations, to focus on the advancement of medical education and the promotion of human health rather than engaging in politically motivated actions that may undermine the collaborative nature of their mission; and

Whereas, censure of a member society based solely on the political or military policies of its host government may unfairly penalize medical students who are working toward positive change and who may not have control over their government's policies; therefore be it

RESOLVED, that our American Medical Association adopt a policy opposing the censure of any medical group or society or organization, based on the politics or policies of the local, state or national political leadership, such that the art and science of medicine is kept separate from politics. (Directive to Take Action)

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

Received: 4/21/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-25)

Introduced by: Indiana

Subject: Physician Disclosures of Relationships in Private Equity Held Organizations

Referred to: Reference Committee on Ethics and Bylaws

Whereas, private equity investment in the United States health care system has expanded to $100 billion in all sectors, including nursing homes, hospitals, primary care, and specialty practices; and

Whereas, complex financial arrangements obscure physician relationships with private equity owned entities at the Medicare enrollment level, i.e. Provider, Enrollment, Chain, and Ownership System (PECOS), including employment, shareholder status, or medical directorship(s); and

Whereas, the American Medical Association has policy (D-140.951) which will study and clarify the ethical challenges raised by the expansion of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices; therefore be it

RESOLVED, that our American Medical Association support physician disclosure of private equity relationship(s), including employment, shareholder status, or medical directorship(s) at any accredited education function that bears continuing AMA medical education credit or approval through the Accreditation Council for Continuing Medical Education (New HOD Policy); and be it further

RESOLVED, that our AMA support physician disclosure of private equity relationship(s) for any committee member that reviews state or federal government (i.e. The Relative Value Scale Update Committee) resource allocation as it pertains to provision of medical services. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/16/25

RELEVANT AMA POLICY

D-140.951 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
Our American Medical Association will study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices. Citation: Res. 026, A-22; Reaffirmed: BOT Rep. 14, A-23.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-25)

Introduced by: LGBTQ+ Section

Subject: Opposition to Censorship in Public Libraries

Referred to: Reference Committee on Ethics and Bylaws

Whereas, public libraries are widely trusted civic institutions with an extensive population reach, receiving an estimated four million visits each day across over 16,500 public libraries nationwide, that serve as an essential community resource to advance population health and address health disparities[1-4]; and

Whereas, a report by the American Library Association has demonstrated that book challenges have become increasingly prevalent over the past four years with over 4200 unique book titles in public and school libraries being challenged during 2023, representing a 65% increase compared to the previous year, of which nearly 1500 were banned[5,6]; and

Whereas, book challenges are especially impacting access to information in public libraries where the number of titles targeted for censorship increased by 92% in 2023 compared to 2022[5]; and

Whereas, over 95% of book bans were enacted without following the best practice guidelines for book challenges outlined by the American Library Association and the National Coalition Against Censorship[7-9]; and

Whereas, a 2023 analysis by the Washington Post demonstrated that book challenges frequently cited out-of-context concerns about “sexual” (61%), “inappropriate” (29%), and “pornographic” (22%) content as part of their rationale[10]; and

Whereas, LGBTQ+ content is frequently conflated with “harmful” or “obscene” content in book, and this has enabled the recent passage of legislation like Idaho’s House Bill 710 that requires libraries to remove any books deemed harmful based on a definition of obscene materials that includes “any homosexual act”[10-13]; and

Whereas, nearly half (47%) of books targeted for censorship in 2023 represent LGBTQ+ or BIPOC stories, and banning books about the lived experiences and histories of these marginalized communities intensifies feelings of exclusion and stigma, exacerbating their pre-existing risks of developing mental health disorders[5,14-16]; and

Whereas, several of the most frequently banned books include titles that discuss sexual assault, diminishing resources to teach empathy for survivors’ stories and build awareness of sexual violence, which is important for youth given that at least 25% of girls and 5% of boys will experience sexual abuse before the age of 18 and 67% of these incidents go unreported[11,17-20]; and

Whereas, the majority of banned books are young adult books, middle grade books, chapter books, or picture books specifically written and selected for younger audiences, with many of

targeted titles like “It’s Perfectly Normal” providing age-appropriate references to sexuality and real-world context for concepts covered in comprehensive sexual education classes[11,21,22]; and

Whereas, a national 2015 survey found that 84% of teens searched for sexual health information online – including topics like sexually transmitted infections, puberty, pregnancy, sexual assault, and intimate partner violence – but several teens also reported finding “negative” health information with 43% encountering online pornography in these searches[23]; and

Whereas, the American Library Association has launched Unite Against Book Bans, which is a national coalition that the AMA has not yet partnered with, in support of “each person’s constitutionally protected right to choose and read books that raise important issues and lift up the voices of those who are often silenced”[5,24]; and

Whereas, at least 129 library-adverse bills were introduced in 2024, and although most were unsuccessful in current legislatures, it is difficult to predict the future trajectory of these bills especially in the context of the political proposals to diminish libraries’ roles as neutral and inclusive spaces for access to a wide range of information[12,25,26]; and

Whereas, lawsuits challenging book bans implemented in conservative states like Texas and Iowa have been heard in federal courts with mixed success in blocking overreaching legislation that would require removal of books related to gender identity and sexual orientation[27,28]; and

Whereas, the US Supreme Court has previously heard a case on the removal of books from school libraries in Island Trees School District v. Pico, and in April 2025, the US Supreme Court is set to hear a new case of parents who object to their children reading developmentally appropriate books with LGBTQ+ themes in schools[29-31]; and

Whereas, various bills and resolutions have been introduced in the US House of Representatives to address the national issue of discriminatory book bans in public libraries without succes[32,33,34]; and

Whereas, under the new presidential administration and guidance from its recent executive orders, agencies like the Department of Education and the Department of Defense have taken actions in support of restricting access to books and health content curricula dealing with LGBTQ+ themes, even going so far as to revoke all guidance characterizing book bans as civil rights violations[35,36,37]; therefore be it

RESOLVED, that our American Medical Association support efforts to safeguard free access to diverse health information by preventing publicly funded entities from censoring books or educational materials in a manner that discriminates on the basis of race, nationality, gender identity, sexual orientation, religion, disability, political affiliation, or socioeconomic status (New HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-60.898, “Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools” by addition and deletion as follows:

Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools and Libraries, H-60.898
1. Our American Medical Association opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation, and gender identity in schools, or educational curricula, or public libraries.

2. Our AMA will support policies that ensure an inclusive, well-rounded educational environment free from censorship of discussions surrounding sexual orientation, sexuality, and gender identity in public schools. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/2025

REFERENCES

1. Horrigan JB. Libraries at the Crossroads. *Pew Research Center*. Published September 15, 2015. Accessed September 9, 2024. https://www.pewresearch.org/internet/2015/09/15/libraries-at-the-crossroads/
2. Rosa KS. The State of America's Libraries 2019: A Report From the American Library Association. *American Libraries*; 2019. Accessed September 9, 2024. https://www.ala.org/sites/default/files/news/content/2019-soal-report-final-accessible.pdf
3. Morgan AU, Dupuis R, D'Alonzo B, et al. Beyond Books: Public Libraries As Partners For Population Health. *Health Aff (Millwood)*. 2016;35(11):2030-2036. doi:10.1377/hlthaff.2016.0724
4. Philbin MM, Parker CM, Flaherty MG, Hirsch JS. Public Libraries: A Community-Level Resource to Advance Population Health. *J Community Health.* 2019;44(1):192-199. doi:10.1007/s10900-018-0547-4
5. American Library Association reports record number of unique book titles challenged in 2023. *American Library Association*. Published March 14, 2024. Accessed September 9, 2024. https://www.ala.org/news/2024/03/american-library-association-reports-record-number-unique-book-titles
6. PEN America Index of School Book Bans – Fall 2022. *PEN America: The Freedom to Write*. Accessed September 9, 2024. https://pen.org/book-bans/index-of-school-book-bans-2022/
7. Friedman J, Magnusson T, Baeta S, et al. Banned in the USA: The Growing Movement to Censor Books in Schools. *PEN America: The Freedom to Write.* Published September 19, 2022. Accessed September 9, 2024. https://pen.org/report/banned-usa-growing-movement-to-censor-books-in-schools/
8. Guidelines for Reconsideration Committees. *American Library Association*; Updated 2021. Accessed September 9, 2024. https://www.ala.org/tools/challengesupport/reconsiderationcommittees
9. Considerations and Guidelines for School Officials. *National Coalition Against Censorship*. Published April 30, 2019. Accessed September 9, 2024. https://ncac.org/news/blog/guidelines-school-officials
10. Natanson H. Objection to Sexual, LGBTQ+ Content Propels Spike in Book Challenges. *The Washington Post*. Updated June 9, 2023. Accessed September 9, 2024. https://www.washingtonpost.com/education/2023/05/23/lgbtq-book-ban-challengers/
11. Meehan K, Magnusson T, Baeta S, Friedman J, et al. Banned in the USA: The Mounting Pressure to Censor. *PEN America: The Freedom to Write*. Published September 1, 2023. Accessed September 9, 2024. https://pen.org/report/book-bans-pressure-to-censor/
12. Warburton B. On the Books: Library Legislation 2024 | Censorship. *Library Journal*. Published Jun 3, 2024. Accessed September 9, 2024. https://www.libraryjournal.com/story/on-the-books-library-legislation-2024-censorship
13. Idaho Statue 18-1514: OBSCENE MATERIALS – DEFINITIONS. Updated July 1, 2024. Accessed September 9, 2024. https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch15/sect18-1514/
14. Pickering, G. "Harmful to Minors": How Book Bans Hurt Adolescent Development. *The Serials Librarian*, 2023;84(1–4):32–45. doi:10.1080/0361526X.2023.2245843
15. Williams DR. Stress and the Mental Health of Populations of Color: Advancing Our Understanding of Race-related Stressors. *J Health Soc Behav*. 2018;59(4):466-485. doi:10.1177/0022146518814251
16. The Trevor Project. 2022 National Survey on LGBTQ Youth Mental Health. *The Trevor Project*. Accessed September 9, 2024. https://www.thetrevorproject.org/survey-2022/
17. Carlisle M. Their Memoir Has Been Removed From School Libraries in 8 States. This Black Queer Author is Fighting Back. *TIME*. Published November 18, 2021. https://time.com/6120915/george-m-johnson-all-boys-arent-blue-book-bans/
18. Anderson LH. *Speak*. New York, NY: Square Fish; 2011.
19. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *J Adolesc Health*. 2014;55(3):329-333. doi:10.1016/j.jadohealth.2013.12.026
20. Gewirtz-Meydan A, Finkelhor D. Sexual Abuse and Assault in a Large National Sample of Children and Adolescents. *Child Maltreat*. 2020;25(2):203-214. doi:10.1177/1077559519873975
21. Harris RH and Emberley M. *It's Perfectly Normal: A Book About Changing Bodies, Growing Up, Sex and Sexual Health*. 3rd ed. Somerville, Massachusetts: Candlewick Press; 2009.
22. Wood E. Pushing the Envelope: Exploring Sexuality in Teen Literature. *The Journal of Research on Libraries and Young Adults*. Published November 2, 2010. Accessed September 9, 2024. https://www.yalsa.ala.org/jrlya/2010/11/pushing-the-envelope-exploring-sexuality-in-teen-literature/
23. Teens, Health, and Technology: A National Survey. *Northwestern University, School of Communication, Center on Media and Human Development*. Published June 2015. Accessed September 9, 2024. https://cmhd.northwestern.edu/wp-content/uploads/2015/05/1886_1_SOC_ConfReport_TeensHealthTech_051115.pdf
24. Organizational Partners. *Unite Against Book Bans*. https://uniteagainstbookbans.org/partners/
25. Legislation of Concern in 2024. *EveryLibrary*. Published April 22, 2024. Accessed September 9, 2024. https://www.everylibrary.org/billtracking
26. Eliminate Funding for the Institute of Museum and Library Services. *Heritage Foundation*. Accessed September 9, 2024. https://www.heritage.org/budget/pages/recommendations/1.500.15.html

27. Serrano A. Federal Judge Bars Texas From Enforcing Book Rating Law. *The Texas Tribune*. Updated September 1, 2023. Accessed September 9, 2024. https://www.texastribune.org/2023/08/31/texas-book-rating-lawsuit/
28. Modan N. Iowa's Sweeping 'Don't Say Gay' Law Hits Roadblock Ahead of Implementation. *K-12 Dive*. Published January 3, 2024. Accessed September 9, 2024. https://www.k12dive.com/news/iowa-dont-say-gay-law-preliminary-injunction/703531/
29. Modan N. Book Ban Lawsuits One Step Closer to Supreme Court. *K-12 Dive.* Published June 13, 2024. Accessed September 9, 2024. https://www.k12dive.com/news/book-ban-lawsuits-supreme-court-appeals-circuit/718851/
30. *Island Trees Sch. Dist. v Pico by Pico*. 457 U.S. 853 (1982). https://supreme.justia.com/cases/federal/us/457/853/#tab-opinion-1954633
31. Mahmoud v Taylor. *SCOTUSblog*. https://www.scotusblog.com/case-files/cases/mahmoud-v-taylor/
32. Fight Book Bans Act of 2023, HR 6592, 118th Cong (2023-2024). https://www.congress.gov/bill/118th-congress/house-bill/6592/text
33. Books Save Lives Act of 2023, HR 6830, 118th Cong (2023-2024). https://www.congress.gov/bill/118th-congress/house-bill/6830/text
34. A Resolution Expressing Concern About the Spreading Problem of Book Banning and the Proliferation of Threates to Freedom of Expression in the United States, S.Res.372, 118th Cong (2023-2024). https://www.congress.gov/bill/118th-congress/senate-resolution/372?q=%7B%22search%22%3A%22book+ban%22%7D&s=1&r=1
35. Ending Radical Indoctrination in K-12 Schooling. *The White House*. Published January 29, 2025. Accessed February 25, 2025. https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-indoctrination-in-k-12-schooling/
36. U.S. Department of Education Ends Biden's Book Ban Hoax. *U.S. Department of Education.* Published January 24, 2025. Accessed February 25, 2025. https://www.ed.gov/about/news/press-release/us-department-of-education-ends-bidens-book-ban-hoax
37. DODEA adds lessons to 'do not use' list sent to schools worldwide. *Stars and Stripes.* Published February 7, 2025. Accessed February 25, 2025. https://www.stripes.com/theaters/europe/2025-02-07/dodea-removes-book-pending-review-16753412.html

RELEVANT AMA POLICY

Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools, H-60.898

1. Our American Medical Association opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation, and gender identity in schools or educational curricula.

2. Our AMA will support policies that ensure an inclusive, well-rounded educational environment free from censorship of discussions surrounding sexual orientation, sexuality, and gender identity in public schools.

[Res. 442, A-22]

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

2. Our AMA urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; … (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils.

9. Our AMA supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent.

10. Our AMA encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

[CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Apended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16, Appended: Res. 414, A-18; Appended Res. 428, A-18; Modified: Res. 413, A-22; Reaffirmation: Res. 413, A-24]

Sexual Assault Education and Prevention in Public Schools, H-515.953
Our AMA supports state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. [Res. 209, I-18]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, H-160.991
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. [CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation, A-12; Modified: Res. 08, A-16; Modified Res. 903, I-17; Modified Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18; Reaffirmed: CSAPH Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 004
(A-25)

Introduced by: Minority Affairs Section

Subject: Reducing the Harmful Impacts of Immigration Status on Health

Referred to: Reference Committee on Ethics and Bylaws

Whereas, undocumented workers, accounting for 8.3 million of the U.S. workforce in 2022 and contributing over $5 billion in federal taxes, are vital to industries like agriculture, construction, and healthcare but often face wage theft, poor conditions, lack of health insurance, and workplace bullying[1-8]; and

Whereas, the strenuous labor demands and restricted access to basic rights experienced by undocumented workers have been linked to higher rates of alcoholism, depression, anxiety, and social isolation[9-12]; and

Whereas, despite facing systemic human rights violations, undocumented workers are often unable to assert fundamental rights due to fear of deportation, limited legal protections, and policies that violate international standards for workplace equality[13]; and

Whereas, the Department of Labor recognizes that migrant workers, regardless of immigration status, are entitled to rights such as forming unions, receiving minimum wage, and protection from discrimination, harassment, and retaliation, while undocumented workers face barriers that impact their employment, healthcare access, and overall quality of life[14]; and

Whereas, the E-Verify system, which requires employers to check immigration status before hiring, has led to over 300,000 legal workers being denied employment due to database errors, failed to significantly reduce the number of employed undocumented workers, and resulted in reduced wages for undocumented workers, forcing them to work longer hours to make up for lost income[15-16]; and

Whereas, the use of immigration enforcement in the workplace creates an environment of coercion and exploitation for undocumented workers, whose vulnerability extends beyond work to housing, healthcare, and basic needs, with limited legal protections and economic disparities perpetuating a cycle of abuse and leaving them with few options for recourse or recovery[9,17-19]; and

Whereas, undocumented workers have limited options to seek care through community health clinics and federally qualified health centers, which often operate on limited resources and may not be able to serve the comprehensive needs of undocumented workers due to lack of healthcare options outside of working hours, translation services, cultural competency, and lack of funding[20,21]; and

Whereas, despite contributing taxes and supporting the Medicare Trust Fund, nearly half of undocumented immigrants remain uninsured due to ineligibility for Medicaid, CHIP, Medicare, or ACA Marketplace coverage, relying instead on emergency Medicaid under EMTALA, which cost $974 million of the $3.3 trillion in national healthcare expenditures[22,23]; and

Whereas, immigration status significantly impacts health outcomes, with undocumented patients experiencing higher mortality rates compared to citizens due to limited access to preventive and comprehensive healthcare[24,25]; and

Whereas, undocumented individuals ineligible for federal health coverage often have to rely on costly emergency department care for chronic conditions like dialysis, increasing mortality and healthcare expenses[26]; and

Whereas, expanding healthcare access for undocumented people reduces emergency room utilization, lowers overall spending, and improves health outcomes through earlier diagnosis, preventive screenings, and better management of chronic conditions[20,27]; and

Whereas, organizations like the Occupational Safety and Health Administration (OSHA), the National Employment Law Project, and the Virginia Legal Aid Justice Center work to protect undocumented workers through visa support, policy advocacy, and improved labor laws[28-30]; and

Whereas, national and local groups, including National COSH, provide undocumented workers with education, legal services, and safety training, though such resources often fail to reach isolated or rural communities, leaving many unaware of their rights and protections[31-38]; and

Whereas, the threat of deportation prevents undocumented workers from reporting labor violations and exacerbates mental health issues, poverty, and child safety risks among immigrant families[1,40-43]; and

Whereas, while the Department of Homeland Security's deferred action process offers protection from immigration-related retaliation and access to critical resources, its limitations, including a complex application process, language barriers, and temporary protections, leave many non-citizen workers vulnerable to harassment and termination[44-46]; and

Whereas, undocumented individuals, including Deferred Action for Childhood Arrivals (DACA) recipients, face significant barriers to legalization, including limited asylum appointments via the U.S. Customs and Border Protection (CBP) One App, high documentation costs, visa backlogs, and restrictive immigration policies[47-51]; and

Whereas, the UN High Commissioner for Refugees (UNHCR) affirms the right to seek asylum, but high asylum-seeker volumes at the U.S.-Mexico border limit this right, increasing the risk of undocumented workers and abuse, while asylum provides legal protections and benefits not available to undocumented workers[52-54]; and

Whereas, family reunification programs help alleviate the mental health effects of separation by reuniting legalized immigrants with their families, while undocumented children, especially unaccompanied minors, face significant legal and emotional challenges, including difficulties obtaining citizenship and lack of essential services[55-56]; and

Whereas, since 2021, over 400,000 unaccompanied minors have entered the U.S. to escape poverty and violence, many working in unsafe jobs with insufficient safety oversight, which increases the risk of injury and mortality[57]; and

Whereas, unaccompanied minors also face increased stressors due to lack of parental guidance and legal protections, with the Central American Minors (CAM) program offering some children a pathway to refugee or parolee status, helping over 5,000 individuals since 2014[58-63]; and

Whereas, coalitions such as Refugee Council USA, which includes Amnesty International and OXFAM as members, can amplify advocacy efforts and allow the AMA to streamline its advocacy

efforts and broaden its reach by collaborating on initiatives to healthcare access and policy reform for immigrant populations[64]; therefore be it

RESOLVED, that our American Medical Association support protecting the human right to seek asylum (New HOD Policy); and be it further

RESOLVED, that our AMA support pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA) recipients and Dreamers (New HOD Policy); and be it further

RESOLVED, that our AMA support family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S. (New HOD Policy); and be it further

RESOLVED, that our AMA support deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/2025

REFERENCES

1. Segarra P, Prasad A. Undocumented immigrants at work: invisibility, hypervisibility, and the making of the modern slave. Humanit Soc Sci Commun. 2024;11(45). doi:10.1057/s41599-023-02449-5
2. Refugees and migrants in times of COVID-19: mapping trends of public health and migration policies and practices. Geneva: World Health Organization. Published 2021. Accessed August 16, 2024. https://www.ncbi.nlm.nih.gov/books/NBK577923/
3. Passel JS, Krogstad JM. What we know about unauthorized immigrants living in the U.S. Pew Research Center. Published July 22, 2024. Accessed August 5, 2024. https://www.pewresearch.org/short-reads/2023/11/16/what-we-know-about-unauthorized-immigrants-living-in-the-us/#:~:text=Unauthorized%20immigrants%20in%20the%20labor%20force&text=Overall%2C%20about%207.8%20million%20unauthorized
4. Krogstad JM, Lopez MH, Passel JS. A majority of Americans say immigrants mostly fill jobs U.S. citizens do not want. Pew Research Center. Published June 10, 2020. Accessed August 5, 2024. https://www.pewresearch.org/short-reads/2020/06/10/a-majority-of-americans-say-immigrants-mostly-fill-jobs-u-s-citizens-do-not-want/
5. Undocumented Immigrants: How immigration plays a critical role. New American Economy. Published 2015. Accessed August 5, 2024. https://www.newamericaneconomy.org/issues/undocumented-immigrants/
6. Svajlenka N. Protecting Undocumented Workers on the Pandemic's Front Lines. American Progress. Published December 2, 2020. Accessed August 5, 2024. https://www.americanprogress.org/article/protecting-undocumented-workers-pandemics-front-lines-2/
7. Svajlenka NP. Undocumented Immigrants in Health Care Roles and Settings. Center for American Progress. Published February 2, 2021. Accessed August 24, 2024. https://cdn.americanprogress.org/content/uploads/2021/01/01114801/EW-Health-factsheet.pdf
8. Saleem R, Pagan-Ortiz ME, Morrill Z, Brodt M, Andrade L. "I thought it would be different": Experiences of structural violence in the lives of undocumented Latinas.. *Peace and Conflict: Journal of Peace Psychology*. 2020;26(2):171-180. doi:10.1037/pac0000420
9. Garcia Quijano JA. Workplace Discrimination and Undocumented First-Generation Latinx Immigrants. The University of Chicago Crown Family School of Social Work, Policy, and Practice. Published 2020. Accessed August 14, 2024. https://crownschool.uchicago.edu/student-life/advocates-forum/workplace-discrimination-and-undocumented-first-generation-latinx
10. Fernandez-Esquer ME, Ibekwe LN, Guerrero-Luera R, King YA, Durand CP, Atkinson JS. Structural Racism and Immigrant Health: Exploring the Association Between Wage Theft, Mental Health, and Injury among Latino Day Laborers. *Ethnicity & Disease*. 2021;31(Suppl):345-356. doi:10.18865/ed.31.s1.345
11. Negi NJ, Siegel J, Calderon M, Thomas E, Valdez A. "They Dumped Me Like Trash": The Social and Psychological Toll of Victimization on Latino Day Laborers' Lives. *American Journal of Community Psychology*. Published online December 10, 2019. doi:10.1002/ajcp.12406

12. Haro AY, Kuhn R, Rodriguez MA, Theodore N, Melendez E, Valenzuela A. Beyond Occupational Hazards: Abuse of Day Laborers and Health. *Journal of Immigrant and Minority Health*. 2020;22(6):1172-1183. doi:10.1007/s10903-020-01094-3
13. Bhatnagar C. Human Rights Abuse In Plain Sight: Migrant Workers in the U.S. American Civil Liberties Union. Published December 18, 2009. Accessed August 14, 2024 https://www.aclu.org/news/national-security/human-rights-abuse-plain-sight-migrant-workers-us
14. Migrant Worker Rights. U.S. Department of Labor. Accessed August 8, 2024. https://www.dol.gov/general/migrantworker/rights#:~:text=You%20have%20the%20right%20to%20be%20treated%20without%20discrimination%20or
15. Fact sheet: E-verify. National Immigration Forum. April 26, 2019. Accessed August 25, 2024. https://immigrationforum.org/article/fact-sheet-e-verify/.
16. Bier DJ. The Facts About E-Verify: Use Rates, Errors, and Effects on Illegal Employment. Cato Institute. January 31, 2019. Accessed August 25, 2024. https://www.cato.org/blog/facts-about-e-verify-use-rates-errors-effects-illegal-employment.
17. Chávez TA, Vences SC, Irazoqui Ruiz Y, De Luna Navarro J, Rodriguez F, Aranda I. Critical Incidences in U.S. Health Care Systems Experienced by Undocumented Young Adults. Health equity. 2021;5(1): 569–576. doi:10.1089/heq.2020.0154
18. Borjas GJ, Cassidy H. The wage penalty to undocumented immigration. Labour Economics. 2019;61:101757. doi:10.1016/j.labeco.2019.101757
19. Passel JS. A Portrait of Unauthorized Immigrants in the United States. Pew Research Center. Published April 14, 2009. Accessed September 5, 2024. https://www.pewresearch.org/race-and-ethnicity/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states/
20. Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. Risk management and healthcare policy. 2015;8, 175–183. doi:10.2147/RMHP.S70173
21. Drishti P, Artiga S, Hamel L, Schumacher S, Kirzinger A, Presiado M, and Kearny A. Health and health care experiences of immigrants: The 2023 KFF/LA Times Survey of immigrants. KFF. September 17, 2023. Accessed September 2, 2024. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.
22. Key Facts on Health Coverage of Immigrants. Kaiser Family Foundation. Updated June 26. 2024. Accessed September 2, 2024. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/
23. Fact Sheet: Undocumented Immigrants and Federal Health Care Benefits. National Immigration Forum. Published September 21, 2022. https://immigrationforum.org/article/fact-sheet-undocumented-immigrants-and-federal-health-care-benefits/#:~:text=Due%20to%20the%20Personal%20Responsibility
24. Cabral J, Cuevas AG. Health Inequities Among Latinos/Hispanics: Documentation Status as a Determinant of Health. Journal of Racial and Ethnic Health Disparities. 2020;7:874-879. doi:10.1007/s40615-020-00710-0
25. Hill J, Rodriguez DX, McDaniel PN. Immigration status as a health care barrier in the USA during COVID-19. Journal of Migration and Health. 2021;4:100036. doi:10.1016/j.jmh.2021.100036
26. Nguyen OK, Vazquez MA, Charles L, Berger JR, Quinones H, Fuquay R, Sanders JM, Kapinos KA, Halm EA, Makam AN. Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease. JAMA Internal Medicine. 2018;179(2):175-183. doi:10.1001/jamainternmed.2018.5866
27. Gruber, Jonathan and Sabety, Adrienne and Sood, Rishi and Bae, Jin Yung. Reducing Frictions in Healthcare Access: The ActionHealth NYC Experiment for Undocumented Immigrants. National Bureau of Economic Research. Working Paper. March 2022. doi: 10.3386/w29838. http://www.nber.org/papers/w29838.
28. Maurer R. OSHA Given Authority to Grant Protection to Undocumented Workers. Society for Human Resource Management. Published February 15, 2023. Accessed August 10, 2024. https://www.shrm.org/topics-tools/news/risk-management/osha-given-authority-to-grant-protection-to-undocumented-workers
29. Justice4All. Legal Aid Justice Center. Published October 4, 2023. Accessed August 14, 2024. https://www.justice4all.org/what-we-do/workplace/.
30. Fact Sheet: Essential Protections for Immigrant Workers. National Council for Occupational Safety and Health. Published 2023. Accessed August 14, 2024. https://www.nationalcosh.org/resources/update-fact-sheet-essential-protections-immigrant-workers
31. Employment Rights of Undocumented Workers. Legal Aid at Work. Published July 5, 2024. Accessed August 14, 2024. https://legalaidatwork.org/factsheet/employment-rights-of-undocumented-workers/.
32. How We Help. Migrant Legal Aid. Published April 1, 2022. Accessed August 14, 2024. https://migrantlegalaid.org/how-we-help/
33. List of Pro Bono Legal Service Providers. Executive Office for Immigration Review, United States Department of Justice. Published August 8, 2024. Accessed August 14, 2024. https://www.justice.gov/eoir/list-pro-bono-legal-service-providers
34. Know Your Rights. Civil Liberties Defense Center. Published January 27, 2022. Accessed August 14, 2024. https://cldc.org/know-your-rights/#ec37c725e101f7631
35. Know Your Rights. MIRA Coalition. Published February 22, 2024. Accessed August 14, 2024. https://miracoalition.org/resources/know-your-rights/
36. Immigrant Workers. NYCOSH. Published 2024. Accessed August 14, 2024. https://nycosh.org/initiatives/immigrant-workers/
37. Almasalkhi N. Immigrants lack access to legal representation--and not just in immigration law. BIMI-HIFIS Policy Brief series. Published 2019. Accessed August 14, 2024. https://bimi.berkeley.edu/sites/default/files/bimi_policy_brief_almasalkhi_immigrants_lack_access_to_legal_representation.pdf
38. Tipler K, Gates AB. Rights education without rights? Rights workshops and undocumented immigrants in the U.S. Journal of Ethnic and Migration Studies. 2019:1-17. doi:10.1080/1369183x.2019.1591271
39. Santillan D, Regalado K. Mental Health Effects of Deportation on Children with Undocumented Parents: A Systematic Literature Review. Accessed August 25, 2024.https://scholarworks.calstate.edu/downloads/2b88qk587.
40. Deportation threat predicts Latino US citizens and noncitizens' psychological distress, 2011 to 2018. PNAS. February 20, 2024. Accessed August 25, 2024. https://www.pnas.org/doi/10.1073/pnas.2409983121.
41. Rayburn AD, McWey LM, Gonzales-Backen MA. Living under The shadows: Experiences of latino immigrant families at risk for deportation. Family Relations. 2021;70(2):359-373. doi:10.1111/fare.12534

42. Alif A, Battiwala T, Yoshikawa H. The influence of Children's immigration status on households with unauthorized parents. Children and Youth Services Review. August 31, 2024. Accessed September 7, 2024. https://www.sciencedirect.com/science/article/pii/S0190740924004596#ab005
43. Alif A, Nelson BS, Stefancic A, Ahmed R, Okazaki S. Documentation status and psychological distress among New York City Community College students. Cultural Diversity & Ethnic Minority Psychology. 2020;26(1):11-21. doi:10.1037/cdp0000290
44. Process for workers requesting Deferred Action Infographic: Homeland security. U.S. Department of Homeland Security. Accessed August 25, 2024. https://www.dhs.gov/publication/process-workers-requesting-deferred-action-infographic.
45. Kluesner NH, McGrath N, Allen NG, Dilip M, Brenner J. Ethical issues and obligations with undocumented immigrants relying on emergency departments for dialysis. Journal of the American College of Emergency Physicians open. December 29, 2021. Accessed August 25, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8716567/
46. DHS Announces Process Enhancements for Supporting Labor Enforcement Investigations. Homeland Security. Published January 13, 2023. Accessed August 13, 2024. https://www.dhs.gov/news/2023/01/13/dhs-announces-process-enhancements-supporting-labor-enforcement-investigations
47. Deferred action for childhood arrivals (DACA). Immigration Equality. September 19, 2023. Accessed August 25, 2024. https://immigrationequality.org/legal/legal-help/other-paths-to-status/deferred-action-for-childhood-arrivals-daca/#:~:text=Individuals%20who%20have%20deferred%20action,be%20revoked%20at%20any%20time.
48. Brigida A-C. "Trying to win the lottery: CBP one app violates right to asylum," says Human Rights Group. Houston Landing. May 12, 2024. Accessed August 21, 2024. https://houstonlanding.org/trying-to-win-the-lottery-cbp-one-app-violates-right-to-asylum-says-human-rights-group/.
49. Why Don't Immigrants Apply for Citizenship?: There Is No Line for Many Undocumented Immigrants. American Immigration Council. Published October 27, 2021. Accessed August 25, 2024. https://www.americanimmigrationcouncil.org/research/why-don%E2%80%99t-they-just-get-line
50. Hainmueller J, Lawrence D, Gest J, Hotard M, Keslowski R, Latin D. Lifting Barriers to Citizenship. Immigration Policy Lab. Published 2023. Accessed August 25, 2024. https://immigrationlab.org/project/lifting-barriers-to-citizenship/
51. Jain V. The costs of immigrating to United States. The Economic Times. Published May 28, 2021. Accessed August 25, 2024. https://economictimes.indiatimes.com/nri/migrate/the-costs-of-immigrating-to-the-united-states/articleshow/82966455.cms?from=mdr
52. Migrant Workers. United Nation Global Impacts. Published 2024. Accessed August 15, 2024. https://bhr-navigator.unglobalcompact.org/issues/migrant-workers/#:~:text=Unequal%20access%20to%20employment%20rights
53. Fact sheet: Presidential proclamation to suspend and limit entry and joint DHS-DOJ Interim Final Rule to restrict asylum during high encounters at the southern border: Homeland security. U.S. Department of Homeland Security. June 4, 2024. Accessed August 21, 2024. https://www.dhs.gov/news/2024/06/04/fact-sheet-presidential-proclamation-suspend-and-limit-entry-and-joint-dhs-doj.
54. Benefits for refugees. The Administration for Children and Families. Accessed August 21, 2024. https://www.acf.hhs.gov/orr/fact-sheet/refugee-benefits.
55. Hampton K, Raker E, Habbach H, Camaj Deda L, Heisler M, Mishori R. The psychological effects of forced family separation on asylum-seeking children and parents at the US-mexico border: A qualitative analysis of Medico-legal documents. PloS one. November 24, 2021. Accessed August 25, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8612557/.
56. Technical assistance program. Young Center. Accessed August 25, 2024. https://www.theyoungcenter.org/technical-assistance-program
57. Lopez LB, Dubnow S. How child migrants are put to work in unsafe and illegal conditions. PBS News Hour. Published January 1, 2024. Accessed August 21, 2024. https://www.pbs.org/newshour/show/how-child-migrants-are-put-to-work-in-unsafe-and-illegal-conditions
58. Menjivar C, Perreira KM. Undocumented and unaccompanied: children of migration in the European Union and the United States. Journal of Ethnic and Migration Studies. 2017;45(2):197-217. doi:10.1080/1369183X.2017.1404255
59. Waddoups AB, Yoshikawa H, Strouf K. Developmental effects of parent–child separation. Annual Review of Developmental Psychology. December 15, 2019. Accessed September 7, 2024. https://www.annualreviews.org/content/journals/10.1146/annurev-devpsych-121318-085142.
60. Key Health Implications of Separation of Families at the Border (as of June 27, 2018) | KFF. KFF. Published June 27, 2018. Accessed August 25, 2024. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-health-implications-of-separation-of-families-at-the-border/#footnote-260162-11
61. Central American minors (CAM) program. USCIS. March 7, 2024. Accessed August 25, 2024. https://www.uscis.gov/CAM.
62. Fact sheet: Central American minors (CAM) program. National Immigration Forum. March 19, 2021. Accessed August 25, 2024. https://immigrationforum.org/article/fact-sheet-central-american-minors-cam-program/.
63. Campbell AF. New data shows why the U.S. needs more immigrants. Center for Public Integrity. Published February 23, 2024. https://publicintegrity.org/inequality-poverty-opportunity/immigration/new-data-shows-why-the-u-s-needs-more-immigrants/
64. Home - Refugee Council USA. Refugee Council USA -. July 23, 2024. Accessed September 7, 2024. https://rcusa.org/.

RELEVANT AMA POLICY

D-515.979 Intimate Partner Violence Policy and Immigration

Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status. [Res. 002, I-17]

H-65.938 Guiding Principles for the Healthcare of Migrants

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
    a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
    b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
    c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
    d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
    e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems. [Res. 016, A-24]

H-135.935 OSHA Standards for Lead

Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009). [Res. 423, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

D-350.975 Immigration Status is a Public Health Issue

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.

2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23]

H-350.957 Addressing Immigrant Health Disparities
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19]

D-440.927 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. [Res. 254, A-18; Reaffirmed: Res. 259, A-23]

D-365.995 Protecting Workers During Catastrophes
1. Our American Medical Association will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes.
2. Our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate parties develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment during catastrophes. [Res. 411, A-23]

H-60.906 Opposing the Detention of Migrant Children
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

H-315.966 Patient and Physician Rights Regarding Immigration Status
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and

other healthcare providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14]

D-135.967 Advocating for Heat Exposure Protections for All Workers
Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language: (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual’s vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies. [Res. 502, I-21]

H-130.967 Action Regarding Illegal Aliens
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

D-440.985 Health Care Payment for Undocumented Persons
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. [Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform
1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the"coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23]

H-430.976 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.
2. Our AMA supports:

(a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.

(b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person's incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.

3. Our AMA encourages:

(a) Congress and state legislatures to clarify the meaning of "employee" to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.

(b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.

(c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.

(d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.

4. Our AMA encourages:

(a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.

(b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.

(c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.

(d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.

5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.

6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors. [BOT Rep. 02, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
A-25

Introduced by: Minority Affairs Section

Subject: Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities

Referred to: Reference Committee on Ethics and Bylaws

Whereas, spirituality is important to many patients with serious illness;[1] and

Whereas, frequent religious service attendance was associated with lower risk of all-cause mortality, suicide, and depression;[2] and

Whereas, early research indicates broad agreement that religion is a social determinant of health and involvement in religion is linked to mostly beneficial health outcomes;[3] and

Whereas, many faiths, including but not limited to Islam, Christianity, Judaism, Buddhism, and Baha'i preach daily prayer, reflection, or meditation as spiritual practices;[4] and

Whereas, the most likely religious group to experience discrimination in institutional settings were Muslims, according to The Institute for Social Policy and Understanding's (ISPU) American Muslim Poll 2022: A Politics and Pandemic Status Report;[5] and

Whereas, numerous studies have highlighted how the lack of cultural competence and healthcare accommodations, such as prayer spaces, are reasons Muslim patients delay healthcare, and Muslim patients have expressed that it is difficult for them to complete their obligatory daily prayers when admitted to in-patient medical institutions and while accessing medical care;[6–8] and

Whereas, many physicians note that their religion and faith has contributed positively to providing exceptional patient care;[9] and

Whereas, a 2021 study found an association between better spiritual well-being of residents with greater sense of work accomplishment, overall self-rated health, decreased burnout and depressive symptoms;[10] and

Whereas, a 2021 study found that identification as an active participant within a religious affiliation had statistically significant lower burnout scores among medical students ;[11] and

Whereas, Muslims must perform ablution, or *wudhu*, before prayer and pray 5 times a day in a quiet, clean space;[6,7] and

Whereas, Oriental Orthodox Christians must pray the canonical hours seven times a day, and Jewish law requires Jews to pray three times a day;[12,13] and

Whereas, the provision of spiritual care in the medical care of patients with serious illness is associated with better end-of-life outcomes;[1] and

Whereas, results from a survey following implementation of reflection spaces in the hospital showed that 90% of responders displayed a preference for using the reflection room versus a hospital unit;[14] and

Whereas, interfaith prayer and reflection rooms are a viable solution to providing diverse student populations a space for spirituality, while also creating an opportunity for awareness of religious pluralism on university campuses;[15] and

Whereas, medical students would feel more supported if their religious and cultural beliefs are valued;[16] and

Whereas, recently, some medical institutions and schools are recognizing the importance and need for interfaith prayer spaces and have started to create those spaces for their students and personnel;[16-19] and

Whereas, Liaison Committee on Medical Education (LCME) standard IS-16 and element 3.3 state that medical education programs must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds;[20] and

Whereas, in 2011, the Association of American Medical Colleges (AAMC) "encouraged medical institutions to embrace a framework for diversity that included removing social…barriers to diversity," but stated almost a decade later that this has not happened;[21] and

Whereas, the AAMC's Chief Diversity and Inclusion Officer, David A. Acosta, MD, has stated that true equity is reached when "*every* person in the academic medical community" can obtain their full potential regardless of their social identity;[22] and

Whereas, AMA's 2024-2025 Organizational Strategic Plan to Advance Health Equity will "amplify and integrate often 'invisible-ized' narratives of historically marginalized physicians and patients" in all that the AMA does;[23] and

Whereas, the AMA states it is committed to maintaining diversity, equity, and inclusion among medical students and physicians;[24] and

Whereas, Policy H-160.900 states that the AMA recognizes the impact spirituality has on health and encourages patient access to spirituality;[25] and

Whereas, Policy D-200.985 states that the AMA will encourage the LCME to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty;[26] and

Whereas, Policy H-295.927 encourages the AMA, LCME, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students;[27] and

Whereas, Policy D-350.996 states that as part of their advocacy and public health efforts, the AMA will incorporate strategies that eliminate minority health care disparities;[28] therefore be it

RESOLVED, that our American Medical Association support the establishment and maintenance of dedicated interfaith prayer and reflection spaces in medical schools, teaching hospitals, and healthcare facilities, including spaces for ritual purification, as a component of

fostering inclusive, supportive environments for patients, students, and healthcare workers from all religious and spiritual backgrounds (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and other relevant accrediting bodies to consider access to interfaith prayer, reflection, and purification spaces as part of their standards related to diversity, equity, inclusion, and learner well-being (New HOD Policy); and be it further

RESOLVED, that our AMA encourage medical schools and healthcare institutions to engage affected communities, including students, trainees, and patients from diverse religious and spiritual traditions, in the planning, implementation, and upkeep of interfaith prayer and reflection spaces to ensure these spaces are welcoming, accessible, and responsive to user needs (New HOD Policy); and be it further

RESOLVED, that our AMA support the development, evaluation, and dissemination of best practices for implementing inclusive interfaith prayer, reflection, and purification spaces in clinical and educational settings, including research on their impact on learner well-being, patient experience, and institutional culture. (Directive to Take Action)

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

Received: 4/21/25

REFERENCES

1. Balboni TA, VanderWeele TJ, Doan-Soares SD, et al. Spirituality in Serious Illness and Health. JAMA. 2022;328(2):184-197. doi:10.1001/jama.2022.11086
2. Chen Y, Kim ES, VanderWeele TJ. Religious-service attendance and subsequent health and well-being throughout adulthood: evidence from three prospective cohorts. Int J Epidemiol. 2020;49(6):2030-2040. doi:10.1093/ije/dyaa120
3. Kawachi I. Invited Commentary: Religion as a Social Determinant of Health. American Journal of Epidemiology. 2019;189(12):1461-1463. doi:https://doi.org/10.1093/aje/kwz204
4. Swihart DL, Yarrarapu SNS, Swihart DL, Yarrarapu SNS, Martin RL. Cultural Religious Competence In Clinical Practice. In: Cultural Religious Competence In Clinical Practice. StatPearls Publishing; 2022. Accessed March 1, 2023. http://www.ncbi.nlm.nih.gov/books/NBK493216/
5. Mogahed D, Ikramullah E, Chouhoud Y. American Muslim Poll 2022: A Politics and Pandemic Status Report. Institute for Social Policy and Understanding. Published August 23, 2022. Accessed September 22, 2022. https://www.ispu.org/american-muslim-poll-2022-1/
6. Padela AI, Gunter K, Killawi A, Heisler M. Religious Values and Healthcare Accommodations: Voices from the American Muslim Community. J Gen Intern Med. 2012;27(6):708-715. doi:10.1007/s11606-011-1965-5
7. Attum B, Hafiz S, Malik A, Shamoon Z. Cultural Competence in the Care of Muslim Patients and Their Families. In: Cultural Competence in the Care of Muslim Patients and Their Families. StatPearls Publishing; 2022. Accessed February 9, 2023. http://www.ncbi.nlm.nih.gov/books/NBK499933/
8. Vu M, Azmat A, Radejko T, Padela AI. Predictors of Delayed Healthcare Seeking Among American Muslim Women. J Womens Health. 2016;25(6):586-593. doi:10.1089/jwh.2015.5517
9. Boyle P. A place for faith: Doctors bring spirituality to work. AAMC. Published March 15, 2022. Accessed March 1, 2023. https://www.aamc.org/news-insights/place-faith-doctors-bring-spirituality-work
10. Chow HHE, Chew QH, Sim K. Spirituality and religion in residents and inter-relationships with clinical practice and residency training: a scoping review. BMJ Open. 2021;11(5):e044321. doi:10.1136/bmjopen-2020-044321
11. Haghnegahdar M, Sharma P, Hubbard KP, White WA. The Influence of Religious Belief on Burnout in Medical Students. Mo Med. 2021;118(1):63-67.
12. Mindel N. The Three Daily Prayers. Chabad. Accessed March 8, 2023. https://www.chabad.org/library/article_cdo/aid/682091/jewish/The-Three-Daily-Prayers.htm
13. Kurian FrJ. "Seven Times a Day I Praise You" – The Shehimo Prayers. Malankara Orthodox Syrian Church. Accessed March 8, 2023. http://www.ds-wa.org/seven-times-a-day-i-praise-you-the-sheema-prayers.html
14. Vesely C, Newman V, Winters Y, Flori H. Bringing Home to the Hospital: Development of the Reflection Room and Provider Perspectives. J Palliat Med. 2017;20(2):120-126. doi:10.1089/jpm.2016.0070
15. Johnson K, Laurence P. Multi-Faith Religious Spaces on College and University Campuses. Relig Educ. 2012;39(1):48-63. doi:10.1080/15507394.2012.648579
16. Howard B. Making space for spirituality. AAMC. Published June 25, 2019. Accessed February 9, 2023. https://www.aamc.org/news-insights/making-space-spirituality
17. Gordon T. Hospitals revamp chapels into meditation rooms. Religion News Service. Published July 20, 2010. Accessed March 1, 2023. https://religionnews.com/2010/07/20/hospitals-move-from-chapels-to-meditation-rooms/

18. University of Michigan. On Campus Spaces for Prayer and Reflection. University Union. Published January 11, 2022. Accessed March 5, 2023. https://uunions.umich.edu/on-campus-spaces-for-prayer-and-reflection/
19. The University of Arizona. Reflection room at Health Sciences. The University of Arizona. Published August 13, 2019. Accessed March 8, 2023. https://new.library.arizona.edu/visit/spaces/reflection-room-health-sciences
20. Liaison Committee on Medical Education. Functions and Structure of a Medical School. LCME. Published March 2022. Accessed March 5, 2023. https://lcme.org/publications/
21. AAMC. Diversity in Medicine: Facts and Figures 2019. AAMC. Published 2019. Accessed April 9, 2023. https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019
22. Acosta D. Achieving excellence through equity, diversity, and inclusion. AAMC. Published January 14, 2020. Accessed April 9, 2023. https://www.aamc.org/news-insights/achieving-excellence-through-equity-diversity-and-inclusion
23. American Medical Association. 2024-2025 AMA Organizational Strategic Plan to Advance Health Equity. Available at https://www.ama-assn.org/about/leadership/ama-s-strategicplan-embed-racial-justice-and-advance-health-equity.
24. AMA. The AMA's commitment to workplace diversity, equity and inclusion. American Medical Association. Accessed March 5, 2023. https://www.ama-assn.org/about/ama-career-opportunities/ama-s-commitment-workplace-diversity-equity-and-inclusion
25. AMA. H-160.900 Addressing Patient Spirituality in Medicine. American Medical Association PolicyFinder. Published November 2016. Accessed March 5, 2023. https://policysearch.ama-assn.org/policyfinder/detail/addressing%20patient%20spirituality?uri=%2FAMADoc%2FHOD-160.900.xml
26. AMA. D-200.985 Strategies for Enhancing Diversity in the Physician Workforce. American Medical Association PolicyFinder. Published November 2022. Accessed March 5, 2023. https://policysearch.ama-assn.org/policyfinder/detail/%20D-200.985?uri=%2FAMADoc%2Fdirectives.xml-0-505.xml
27. AMA. H-295.927 Medical Student Health and Well-Being. American Medical Association PolicyFinder. Published June 2013. Accessed March 5, 2023. https://policysearch.ama-assn.org/policyfinder/detail/%22Medical%20Student%20Health%20and%20Well-Being%20H-295.927%22?uri=%2FAMADoc%2FHOD.xml-0-2226.xml
28. AMA. D-350.996 Strategies for Eliminating Minority Health Care Disparities. American Medical Association PolicyFinder. Published June 2022. Accessed March 5, 2023. https://policysearch.ama-assn.org/policyfinder/detail/%22Strategies%20for%20Eliminating%20Minority%20Health%20Care%20Disparities%20D-350.996%22?uri=%2FAMADoc%2Fdirectives.xml-0-1202.xml

RELEVANT AMA POLICY

H-160.900 Addressing Patient Spirituality in Medicine

Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services. [Res. 004, I-16; Modified: Res. 304, A-24]

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

D-350.996 Strategies for Eliminating Minority Health Care Disparities
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. [Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CMS Rep. 03, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-25)

Introduced by: American Association of Public Health Physicians, Medical Student Section

Subject: Military Deception as a Threat to Physician Ethics

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the United States Central Intelligence Agency (CIA)'s use of a fake, physician-led hepatitis immunization program to gather military intelligence in Pakistan in 2011 made legitimate polio vaccination clinics a target for militant violence, with public health workers becoming the target of attacks[1-3]; and

Whereas, disclosure of these operations contributed to a subsequent decline in polio and hepatitis vaccination rates in Pakistan despite an unchanged provision of health services, suggesting the vaccine ruse damaged the reputation of vaccines and of formal medicine in the region[1,4]; and

Whereas, growing global distrust in healthcare institutions and providers is a threat to global vaccine uptake and improved health outcomes[5-7]; and

Whereas, the World Health Organization's declaration of polio's re-emergence as a public health emergency of international concern (PHEIC), political rhetoric surrounding the COVID-19 pandemic, and other emerging threats underscores the importance of political neutrality in public health campaigns and global medical interventions in order to maintain trust in health institutions[1]; and

Whereas, our AMA Code of Medical Ethics serves as the foundational ethical guidance for all AMA policy and a codification of expectations regarding physician conduct and the "responsibility towards patients first and foremost, as well as to society, to other health professionals, and to self", including in settings of armed conflict and military intervention; and

Whereas, our AMA Code of Medical Ethics Opinions 1.1.1, 1.1.3, 8.11, and 11.1.1 provide strong, clear guidance on physicians' ethical responsibilities to prioritize patient welfare, advocate for informed, transparent decision making, protecting vulnerable populations, and protecting patient rights; and

Whereas, current AMA Policy "support[s] medical neutrality, under the principles of the Geneva Convention" (H-520.998) and "support[s] the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime" (D-65.993); and

Whereas, AMA Code of Medical Ethics Opinion 9.7 affirms that while physicians have civic duties, they are not required to perform duties that conflict with fundamental medical ethics, offering guidance limited to medical testimony, court-initiated treatment, capital punishment, interrogation, and torture; and

Whereas, the Geneva Conventions, AMA Code of Medical Ethics, and AMA policies lack clear ethical guidance on physician conduct when government entities use medical, public health, or humanitarian aid deceptively for military gain or non-patient welfare purposes, highlighting a significant gap; and

Whereas, the World Medical Association (WMA), in collaboration with international organizations, has endorsed the Ethical Principles of Care in Times of Armed Conflict and Other Emergencies, which emphasize that healthcare privileges and facilities must only serve healthcare needs, and that physicians' primary ethical obligation is to their patients[8]; and

Whereas, the WMA's Statement in Times of Armed Conflict and Other Situations of Violence reaffirms that physicians must never exploit the vulnerability of the wounded and sick or misuse healthcare privileges for unintended purposes[9]; and

Whereas, the misuse of medical aid as a cover for military intelligence gathering undermines the physician duty to patients and threatens public trust of healthcare providers and institutions; therefore be it

RESOLVED, that our American Medical Association oppose the deceptive use of medical, public health, and humanitarian aid for secret or ulterior motives by government and military entities, including to gather national security intelligence or gain leverage in an armed conflict. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 04/10/2025

REFERENCES

1. Kennedy J. How Drone Strikes and a Fake Vaccination Program Have Inhibited Polio Eradication in Pakistan: An Analysis of National Level Data. *Int J Health Serv*. 2017;47(4):807-825. doi:10.1177/0020731417722888
2. Lancet N. Polio eradication: where are we now? *The Lancet*. 2013;382(9902):1381. doi:10.1016/s0140-6736(13)62196-0
3. Hussain SF, Boyle P, Patel P, et al. Eradicating polio in Pakistan: an analysis of the challenges and solutions to this security and health issue. *Global Health*. 2016;12(63). doi:10.1186/s12992-016-0195-3
4. Martinez-Bravo M, Stegmann A. In Vaccines We Trust? The Effects of the CIA's Vaccine Ruse on Immunization in Pakistan. https://www.cato.org/research-briefs-economic-policy/vaccines-we-trust-effects-cias-vaccine-ruse-immunization-pakistan. Published November 10, 2021.
5. Edelman Trust Institute. 2023 Edelman Trust Barometer. *Special Report: Trust and Health*. Published March 13, 2023. https://www.edelman.com/sites/g/files/aatuss191/files/2023-04/2023%20Edelman%20Trust%20Barometer%20Trust%20and%20Health1.pdf
6. Rozek LS, Jones P, Menon A, Hicken A, Apsley S, King EJ. Understanding Vaccine Hesitancy in the Context of COVID-19: The Role of Trust and Confidence in a Seventeen-Country Survey. *Int J Public Health*. 2021;66:636255. doi:10.3389/ijph.2021.636255
7. Moucheraud C, Guo H, Macinko J. Trust In Governments And Health Workers Low Globally, Influencing Attitudes Toward Health Information, Vaccines. *Health Aff (Millwood)*. 2021;40(8):1215-1224. doi:10.1377/hlthaff.2020.02006
8. Ethical Principles of Health Care in times of armed conflict and other emergencies. *The World Medical Association*. November 28, 2017. https://www.wma.net/policies-post/ethical-principles-of-health-care-in-times-of-armed-conflict-and-other-emergencies/
9. WMA Statement in Times of Armed Conflict and Other Situations of Violence. *The World Medical Association*. Reaffirmed October 2023. https://www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/

RELEVANT AMA POLICY

AMA Code of Medical Ethics Opinion 8.11: Health Promotion & Preventive Care
Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health.

AMA Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships
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 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.

AMA Code of Medical Ethics Opinion 11.1.1: Defining Basic Health Care
Physicians regularly confront the effects of lack of access to adequate care and have a corresponding responsibility to contribute their expertise to societal decisions about what health care services should be included in a minimum package of care for all.

Individually and collectively as a profession, physicians should advocate for fair, informed decision making about basic health care that:

(a) Is transparent.
(c) Protects the most vulnerable patients and populations, with special attention to historically disadvantaged groups.

AMA Code of Medical Ethics Opinion 1.1.3: Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

D-65.993 War Crimes as a Threat to Physicians' Humanitarian Responsibilities
1. Our American Medical Association will implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular.
2. Our AMA will support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs.
3. Our AMA will advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19; Modified: Res. 002, I-22; Reaffirmed: Res. 603, A-24]

H-520.998 Medical Neutrality
Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed in lieu of Res. 601, I-13; Reaffirmed: CEJA Rep. 05, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-25)

Introduced by: Medical Student Section, LGBTQ+ Section

Subject: Use of Inclusive Language in AMA Policy

Referred to: Reference Committee on Ethics and Bylaws

Whereas, in 2019, our American Medical Association established the Center for Health Equity to embed and advance equity across all aspects of health care, including within the American Medical Association itself; and

Whereas, our AMA, in partnership with the Association of American Medical Colleges (AAMC) Center for Health Justice, developed "Advancing Health Equity: A Guide to Language, Narrative and Concepts," a comprehensive health equity communication guide[1]; and

Whereas, AMA policy H-65.942, "Supporting the Use of Gender-Neutral Language," provides a model for broad-based updates to the AMA policy compendium via ongoing use of the reaffirmation and sunset mechanisms; and

Whereas, existing AMA policies continue to utilize other language or terminology that is outdated, obsolete, exclusive, inaccurate, or offensive, which hinders our mission to promote the art and science of medicine and the betterment of public health; and

Whereas, despite this, existing policy is not comprehensively updated to use inclusive language via the sunset and reaffirmation mechanisms unless initiated by resolutions submitted to the House of Delegates (HOD), AMA staff, or an AMA Council[6]; and

Whereas, ad hoc resolutions submitted to the HOD largely result in reactionary, targeted changes to existing policy, creating cyclical administrative burden on AMA staff; and

Whereas, AMA Councils annually have the opportunity to review policies for sunset and have existing, though variable, mechanisms by which to edit policy language in their sunset report, providing a process to proactively update AMA policy to utilize inclusive language; and

Whereas, prior Sunset reports did not fully incorporate gender-neutral language updates, leaving the discrepancies to be identified and rectified by the House of Delegates [2-5]; and

Whereas, there is no explicit and comprehensive policy directive to ensure that future AMA policy or amendments to existing policy are standardized to use inclusive language; therefore be it

RESOLVED, that our American Medical Association, in consultation with relevant parties, including the AMA Center for Health Equity, amend existing policies to ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments (Directive to Take Action); and be it further

RESOLVED, that our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, identify other types of outdated language in AMA policies and devise a timely mechanism for editorial changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/17/25

REFERENCES

1. American Medical Association and Association of American Medical Colleges. (2021). Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.
2. Council on Legislation Sunset Review of 2014 House Policies. BOT-9-A-24, https://www.ama-assn.org/system/files/a24-bot09.pdf
3. Annotated Report of Reference Committee B, A-24. https://www.ama-assn.org/system/files/a24-refcomm-b-annotated.pdf#page=15
4. Council on Medical Service Sunset Review of 2014 House Policies. CMS-1-A-24, https://www.ama-assn.org/system/files/a24-cms01.pdf
5. Annotated Report of Reference Committee G, A-24. https://www.ama-assn.org/system/files/a24-refcomm-g-annotated-report.pdf#page=4
6. Recommendations for Policy Reconciliation, Speakers Report 2-I-24. https://www.ama-assn.org/system/files/i24-handbook-informational-reports.pdf#page=83

RELEVANT AMA POLICY

H-70.912 Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings
Our American Medical Association recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings. [Res. 024, A-19]

H-440.821 Person-First Language for Obesity
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. [Res. 402, A-17; Modified: Speakers Rep., I-17]

H-65.942 Supporting the Use of Gender-Neutral Language
Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies1 internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. [Res. 602, A-23]

D-65.990 Utilization of "LGBTQ" in Relevant Past and Future AMA Policies
1. Our American Medical Association will utilize the terminology “lesbian, gay, bisexual, transgender, and queer plus” and the abbreviation “LGBTQ+” in all future policies and publications when broadly addressing this population.

2. Our AMA will revise all relevant and active policies to utilize the abbreviation “LGBTQ+” in place of the abbreviations “LGBT” and “GLBT” where such text appears.

3. Our AMA will revise all relevant and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer plus” to replace “lesbian, gay, bisexual, and transgender” where such text appears. [Res. 016, A-18; Modified: CCB Rep. 05, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-25)

Introduced by: Medical Student Section

Subject: Humanism in Anatomical Medical Education

Referred to: Reference Committee on Ethics and Bylaws

Whereas, when beginning cadaveric donor dissection, medical students commonly experience negative emotional or physical reactions which they are expected to quickly overcome, even though many continue to feel discomfort and prolonged guilt[1-2]; and

Whereas, the term "donor" can be more humanistic than the objectifying commonly used term "cadaver"[3,4]; and

Whereas, a diverse medical student community should nurture religious, cultural, and spiritual views towards deceased bodies[5-6]; and

Whereas, most schools conduct donor ceremonies before, during, and/or after dissection courses to convey respect and gratitude to donors and their families, but less than half of these schools include donor names in ceremonies[7-9]; and

Whereas, a survey of students who attended a donor ceremony shared more positive responses regarding their studies, reflection on death, and development of empathy compared to those not attend[10]; and

Whereas, memorial ceremonies and/or daily rituals demonstrate positive educational effects and help prevent decline of students' responsibility and respect during dissection courses[1]; and

Whereas, multiple studies show that students appreciate knowing their donors' identities, which increases positive response to working with donors[1,9]; and

Whereas, a study showed that donors supported anonymous disclosure of information after learning that students wanted to know more about their background to establish the idea of their donor as their first patient[11]; and

Whereas, another study found that "person-minded" medical students developed complex rules regarding respectful behavior towards donors, including habits that reinforced donors' humanity, in contrast to "specimen-minded" students[12]; and

Whereas, Indigenous students engaging in a cultural ceremony showed their respect and appreciation to donors, while also supporting their own spiritual and mental health[13]; therefore be it

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, time for HIPAA-compliant

recognition of donor backgrounds, reflection, discussion, and feedback (New HOD Policy); and be it further

RESOLVED, that our AMA supports accommodations for learners' and donors' cultural observances surrounding the deceased when appropriate (New HOD Policy); and be it further

RESOLVED, that our AMA supports donor memorial ceremonies at centers that utilize cadaveric-based human anatomy education programs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/17/25

REFERENCES

1. Chang HJ, Kim HJ, Rhyu IJ, Lee YM, Uhm CS. Emotional experiences of medical students during cadaver dissection and the role of memorial ceremonies: a qualitative study. BMC Med Educ. 2018;18(1):255. Published 2018 Nov 12. doi:10.1186/s12909-018-1358-0
2. Chiou RJ, Tsai PF, Han DY. Impacts of a gross anatomy laboratory course on medical students' emotional reactions in Taiwan: the role of high-level emotions. BMC Med Educ. 2021;21(1):489. Published 2021 Sep 11. doi:10.1186/s12909-021-02923-1
3. Champney TH. A Bioethos for Bodies: Respecting a Priceless Resource. Anat Sci Educ. 2019;12(4):432-434. doi:10.1002/ase.1855
4. Sv S, Maria Francis Y, Karunakaran B, et al. Donor Oath: Respect to the Mortal Teacher to Learn Ethics and Humanitarian Values of Anatomy. Cureus. 2022;14(3):e22941. Published 2022 Mar 7. doi:10.7759/cureus.22941
5. Alvord LA. Medical school accommodations for religious and cultural practices. Virtual Mentor. 2013;15(3):198-201. Published 2013 Mar 1. doi:10.1001/virtualmentor.2013.15.3.ecas3-1303
6. Hadie SNH, Gasmalla HEE, Wadi MM, Zainul Abidin MA, Yusoff MSB. From generosity to gratitude: Exploring Islamic views on body donation, human dissection, and honoring the gift of life. Anat Sci Educ. Published online February 8, 2024. doi:10.1002/ase.2393
7. Halliday NL, Moon MB, O'Donoghue DL, Thompson BM, Crow SM. Transformation and Closure for Anatomical Donor Families that Meet Medical Students. Anat Sci Educ. 2019;12(4):399-406. doi:10.1002/ase.1888
8. Leeper BJ, Grachan JJ, Robinson R, Doll J, Stevens K. Honoring human body donors: Five core themes to consider regarding ethical treatment and memorialization. Anat Sci Educ. Published online January 10, 2024. doi:10.1002/ase.2378
9. Greene SJ, Rosen L. Sharing personal information about anatomical body donors: What first-year medical students want to know and how it affects emotional responses to dissection. Clin Anat. 2019;32(8):1019-1032. doi:10.1002/ca.23389
10. da Rocha AO, Maués JL, Chies GAF, da Silva AP. Assessing the Impact of a Ceremony in Honor of the Body Donors in the Development of Ethical and Humanistic Attitudes among Medical Students. Anat Sci Educ. 2020;13(4):467-474. doi:10.1002/ase.1920
11. Hasselblatt, F., Messerer, D.A.C., Keis, O., Böckers, T.M. and Böckers, A. (2018), Anonymous body or first patient? A status report and needs assessment regarding the personalization of donors in dissection courses in German, Austrian, and Swiss Medical Schools. American Association of Anatomists, 11: 282-293. https://doi.org/10.1002/ase.1744
12. Goss AL, Viswanathan VB, DeLisser HM. Not Just a Specimen: A Qualitative Study of Emotion, Morality, and Professionalism in One Medical School Gross Anatomy Laboratory. Anat Sci Educ. 2019;12(4):349-359. doi:10.1002/ase.1868
13. The University of Arizona Health Sciences. Colleges of medicine host traditional blessing ceremonies. The University of Arizona Health Sciences. August 30, 2023. Accessed March 31, 2024.https://healthsciences.arizona.edu/connect/photos/colleges-medicine-host-traditional-blessing-ceremonies.

RELEVANT AMA POLICY

H-295.896 Conscience Clause: Final Report
Principles to guide exemption of medical students from activities based on conscience include the following:
(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.

(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.
(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
(5) Policies related to exemption based on conscience should be applied consistently.
(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.
(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. [CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: CME Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-25)

Introduced by: New England

Subject: Patient centered health care as a Determinant of Health

Referred to: Reference Committee on Ethics and Bylaws

Whereas, this resolution enforces, and emphasizes the importance of patient centered health care and the role of physicians in supporting informed involuntary patient decision-making; and

Whereas, it is a call for the American Medical Association to advocate for the recognition and reinforcement of patient centered health care as a fundamental personal right. This right empowers individuals to actively engage in their healthcare decisions, ensuring these choices are informed, voluntary and reflective of their personal values and goals; and

Whereas, it is the professional and ethical duty of physicians to facilitate patient centered health care by providing comprehensive information, guidance, and support. Empowering patients to make rigorous ethical decisions, free from coercion, and undue influence; and

Whereas, this commitment underscores respect for patient dignity, and the central role of patients in determining their healthcare journey; and

Whereas, patient centered health care is the foundational, ethical principle, that each person should have the right to make their own decisions about their goals and direction in life, such that they control their own destiny, and claim personal responsibility for their choices, actions, words, and responses to others and to events. It is a defining aspect of the declaration by the World Health Organization in 1988[1] that personal behavior is a major determinant of a person's health; and

Whereas, health is defined as a holistic state of security and well-being; physical, mental, social, and environmental. Health is determined by many factors that are broadly classified as three interrelated, and inter-dependent dimensions; that are attributed to the patient/person individually and collectively, (community/culture); to the environment, in which each person lives, (SDOH), social determinants of health); and that provided by your health profession and healthcare system, with its ability to mentor and sustain wellness; restore and remediate human suffering, illness, and injury; and

Whereas, as trusted members of the profession of medicine, we are obligated to bring safe, rigorous, comprehensive, critical thinking, and actions to those we serve. The road to health and all its dimensions is about the orchestration of personal, environmental and health system (professional) development. It's about assessing and taking meaningful action in the relevant aspects of all three areas, not being unduly preoccupied with one area over another, depending on the health fad of the day; and

Whereas, the Massachusetts Medical Society has made great progress in the development of policy and advocacy that advances the social (environmental) determinants, caregiver development (resilience and burnout) and health system reform there is renewed interest in the

historical traditional area of individual patient development namely personal critical, thinking, behavior, and responsibility which may lead to better outcomes for patients individually and collectively; and

Whereas, the Massachusetts Medical Society has declared and its policy compendium[2] now states that " healthcare is a basic human right – enjoyment of the highest attainable, standard of health in all its dimensions, including healthcare, is a basic human right. The provision of healthcare services, as well as optimizing the social determinants of health is an ethical obligation of a civil society." The challenge thus becomes, how do we fulfill this promise? Despite enormous efforts in reforming our health system, addressing the social determinants of health, and ever-increasing funding by private and government means the gap between the production of illness and injury grows relative to the level of resources available to sustain and restore health. Could it be that asking our patients for help might be a promising idea? John F Kennedy alluded to this issue when he proclaimed in his inaugural address on January 20, 1961. The following quote "ask not what your country can do for you, ask what you can do for your country"; and

Whereas, our patients increasingly ask: "What can I as a patient, family member, or friend do to help sustain, or restore my health, and/or mitigate my suffering and disability? Indeed act to better my life and that of others?"; and

Whereas, patients look to the profession of medicine for answers they are seeking to be active participants in health. The theme of personal responsibility and action is about trusting and effective partnerships, and collaborative relationships that facilitate health. Daniel Johnson, MD as president of our AMA from 1996 to 1997 spoke to the role and obligation of our profession to patients in his presidential address. He spoke of the patient caregiver relationship and its enduring value. He likened it to a stagecoach, full of passengers on a wild ride through a terrifying landscape. The driver, the passengers and the shotgun, are on a journey to health. The medical profession is the shotgun and serves as a guide for the stagecoach, and its powerful horses moving through the hostile countryside. The horses and the stagecoach are the health system. The intent of his story is to illustrate the value, endurance and power of our relationship to one another, the patient physician relationship. It highlights that human relationships are necessary tools to guide a successful, safe and productive life's journey; and

Whereas, with this background in mind, the Ethics Committee of the Massachusetts Medical Society anonymously voted to recommend the following resolution[3] to our House of Delegates. It has been adopted and placed in our policy compendium. We in turn, as we have done many times before, offer it to our AMA for consideration; therefore be it

RESOLVED, that our American Medical Association adopt that patient centered health care is a fundamental right of individuals to actively participate in decisions concerning their health care, allowing them to make informed choices, aligned with their values and goals (New HOD Policy); and be it further

RESOLVED, that our AMA physicians have a professional and moral obligation to empower patients to make informed decisions about their care, free from coercion, or undue influence. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/15/25

REFERENCES

1. https://www.who.int/health-topics/social-determinants-of-health
2. www.massmed.org/policies
3. *See generally, Autonomy: What's Shared Decision Making Have to Do With It? Am J Bioeth. 2018 February ; 18(2): W11–W12. doi:10.1080/15265161.2017.1409844*

RELEVANT AMA POLICY

AMA Code of Medical Ethics
1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians.
Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.

(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.

(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.

(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.

(e) To have the physician and other staff respect the patient's privacy and confidentiality.

(f) To obtain copies or summaries of their medical records.

(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I, IV, V, VIII, IX

AMA Code of Medical Ethics
1.1.4 Patient Responsibilities

Successful medical care requires ongoing collaboration between patients and physicians. Their partnership requires both individuals to take an active role in the healing process.

Autonomous, competent patients control the decisions that direct their health care. With that exercise of self-governance and choice comes a number of responsibilities. Patients contribute to the collaborative effort when they:

(a) Are truthful and forthcoming with their physicians and strive to express their concerns clearly. Physicians likewise should encourage patients to raise questions or concerns.

(b) Provide as complete a medical history as they can, including providing information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

(c) Cooperate with agreed-on treatment plans. Since adhering to treatment is often essential to public and individual safety, patients should disclose whether they have or have not followed the agreed-on plan and indicate when they would like to reconsider the plan.

(d) Accept care from medical students, residents, and other trainees under appropriate supervision. Participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance.

(e) Meet their financial responsibilities with regard to medical care or discuss financial hardships with their physicians. Patients should be aware of costs associated with using a limited resource like health care and try to use medical resources judiciously.

(f) Recognize that a healthy lifestyle can often prevent or mitigate illness and take responsibility to follow preventive measures and adopt health-enhancing behaviors.

(g) Be aware of and refrain from behavior that unreasonably places the health of others at risk. They should ask about what they can do to prevent transmission of infectious disease.

(h) Refrain from being disruptive in the clinical setting.

(i) Not knowingly initiate or participate in medical fraud.

(j) Report illegal or unethical behavior by physicians or other health care professionals to the appropriate medical societies, licensing boards, or law enforcement authorities.

AMA Principles of Medical Ethics: I, IV, VI

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure

Referred to: Reference Committee on Ethics and Bylaws

Whereas, exacting and specific disclosures are a key component of the social compact between physicians and society at large, such that patients can have some assurances the care they receive is not unduly influenced by physicians' financial or contractual obligations; and

Whereas, value-based care payment systems task physicians with not only being care providers, but also with being cost managers; and

Whereas, physicians have reported anecdotally being pushed out of value-based contracts when their practices account for greater spending while lower-spending physicians did not seem to report the same risks; and

Whereas, physicians have reported experiencing pressure to cut medication costs even to the extent of changing patient prescriptions or treatment options specifically due to the threat to outcome scores having a negative impact on physicians' ratings; and

Whereas, regulatory and legislative attempts to address these concerns in the form of sunshine and disclosure laws may not be a comprehensive fix as such laws and regulations are not universal and lead to a patchwork of rules across states; and

Whereas, the effect of transparency on cost and physician and patient behavior is limited with studies showing that exposing patients to greater transparency about their healthcare costs had only a modest association with decreased healthcare spending; and

Whereas, it is not enough to abandon efforts to ensure equity is achieved even if patients themselves are not particularly inclined to pay attention to incentive structures and physicians' ethical code of conduct should still require that physicians make certain disclosures; therefore be it

RESOLVED, that our American Medical Association advocate for legislation at the state and federal level requiring complete disclosure of financial arrangements with physicians that are potentially against patients' best interests, including financial incentives and disincentives, by insurers, facilities that employ physicians, and pharmacy benefit managers (Directive to Take Action); and be it further

RESOLVED, that our AMA produce a report with the aim of updating our Code of Medical Ethics to include guidance on disclosure of financial arrangements between physicians and healthcare facilities, employers, or payors that are potentially against patients' best interests (Directive to Take Action).

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

Received: 2/28/2025

RELEVANT AMA POLICY

Physician Pay-for-Performance Programs H-140.872

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.
Citation: CEJA Rep. 3, I05; Reaffirmed: A-06; Reaffirmed: I-06; Reaffirmed: CEJA Rep. 3, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or

others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report: I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I06; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: BOT Rep. 5, I-16

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
Citation: CMS Rep. 5, A-19; Reaffirmed: CMS Rep. 6, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-25)

Introduced by: Resident and Fellow Section, International Medical Graduates Section

Subject: Opposition of Health Care Entities from Reporting Individual Patient Immigration Status

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) prevents any hospital emergency department that receives Medicare funds from refusing to treat patients for any reason[1]; and

Whereas, Governor Greg Abbott issued an executive order directing the Texas Health and Human Services Commission (HHSC) to collect information on undocumented immigrants immigrant status who utilize Texas public hospitals for inpatient and emergency care[2]; and

Whereas, the executive order directs public hospitals and acute care facilities that receive funding from Medicaid and/or Children's Health Insurance Program (CHIP) to collect information regarding the cost of medical care provided to undocumented immigrants beginning November 1, 2024[2]; and

Whereas, the executive order directs those hospitals and providers to inform the patient that federal law mandates that any response to immigration status questions will not affect patient care[2]; and

Whereas, undocumented immigrants are one of the most marginalized and vulnerable ethnic minority communities in the US and face extreme difficulties accessing healthcare[3]; and

Whereas, the aim of the executive order is to seek compensation from the federal government for care provided to undocumented immigrants since rates of uncompensated care in Texas is high; however, much of this is due to current Texas legislation excluding people from accessing health coverage due to non-expansion of Medicaid and eliminating options for non-US citizens from accessing insurance[4]; and

Whereas, one study demonstrated that undocumented immigrants encounter significant barriers to emergency healthcare currently due to lack of insurance and severity at presentation, increasing the risk of long-term hospitalizations[5]; and

Whereas, similar tracking efforts have been released in Florida where the state found that undocumented immigrants made up 0.8% of hospital visits from June to December of 2023[6]; and

Whereas, at least 50% of those without Deferred Action for Childhood Arrivals (DACA) reported experiencing barriers to healthcare related to documentation status and DACA recipients had 80% decreased odds of facing discrimination when seeking healthcare and 70% decreased odds of documentation status[7]; and

Whereas, experts are predicting in today's climate of anti-immigrant rhetoric and fears of mass deportations, requiring hospital staff to inquire the immigration status of patients before providing care is likely to intimate undocumented immigrants and deter them from seeking medical care for themselves or their children, potentially endangering the health and lives of these families[8]; and

Whereas, as physicians and as the AMA we recognize that enjoyment of the highest attainable standard of health, in all its dimensions, is a basic right (H-65.960); and

Whereas, the use of de-identified healthcare data is an essential method for protecting patient privacy and a sense of security for many patients[9]; and

Whereas, implicit and explicit bias in healthcare directly impact marginalized groups of patients and may lead to discriminatory behavior and potentially suboptimal delivery of healthcare[10]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-440.876, "Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients" by addition and deletion to read:

1. Our American Medical Association opposes
    a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
    b. any policies, regulations, or legislation requiring physicians, ~~and~~ other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status; and
    c. proof of citizenship as a condition of providing health care~~.~~;and
    d. withholding federal funds if institutions fail to comply with policies which mandate collection of a patient's immigration status.

2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports collection of de-identified patient information regarding immigration status for funding and research purposes only. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

REFERENCES

1. Emergency Room Rights | CMS. www.cms.gov. Published September 10, 2024. https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights
2. Governor Abbott Issues Executive Order Requiring Texas Hospitals To Collect, Report Healthcare Costs For Illegal Immigrants. Texas.gov. Published 2024. https://gov.texas.gov/news/post/governor-abbott-issues-executive-order-requiring-texas-hospitals-to-collect-report-healthcare-costs-for-illegal-immigrants
3. Galvan T, Lill S, Garcini LM. Another Brick in the Wall: Healthcare Access Difficulties and Their Implications for Undocumented Latino/a Immigrants. *J Immigr Minor Health*. 2021;23(5):885-894. doi:10.1007/s10903-021-01187-7
4. Brigida AC, Murney M. "A major chilling effect": How Abbott's order could impact immigrants, medical community. Houston Landing. Published August 12, 2024. https://houstonlanding.org/a-major-chilling-effect-how-abbotts-order-could-impact-immigrants-medical-community/
5. Kisa S, Kisa A. "No Papers, No Treatment": a scoping review of challenges faced by undocumented immigrants in accessing emergency healthcare. *Int J Equity Health*. 2024;23(1):184. Published 2024 Sep 14. doi:10.1186/s12939-024-02270-9

6. Desantis R, Weida J. *Hospital Patient Immigration Status Report*.; 2023. Accessed November 8, 2024.https://ahca.myflorida.com/content/download/24244/file/Report_Hospital_Patient_Immigration.pdf
7. Woofter R, Sudhinaraset M. Differences in Barriers to Healthcare and Discrimination in Healthcare Settings Among Undocumented Immigrants by Deferred Action for Childhood Arrivals (DACA) Status. *J Immigr Minor Health*. 2022;24(4):937-944. doi:10.1007/s10903-022-01346-4
8. New Texas executive order requires hospitals to ask about immigrant status. Here's what it means for Texas children and their families. - Children's Defense Fund. Children's Defense Fund. Published November 7, 2024. Accessed November 8, 2024. https://www.childrensdefense.org/blog/texas-hospitals-are-now-required-to-ask-patients-about-their-immigration-status/
9. Gross MS, Hood AJ, Rubin JC, Miller RC Jr. Respect, justice and learning are limited when patients are deidentified data subjects. *Learn Health Syst.* 2022;6(3):e10303. Published 2022 Mar 4. doi:10.1002/lrh2.10303
10. Sabin JA. Tackling Implicit Bias in Health Care. N Engl J Med. 2022 Jul 14;387(2):105-107. doi: 10.1056/NEJMp2201180. Epub 2022 Jul 9. PMID: 35801989; PMCID: PMC10332478.

RELEVANT AMA POLICY

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our American Medical Association opposes:
    a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
    b. any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and
    c. proof of citizenship as a condition of providing health care.
2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.

[Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24]

Health, In All Its Dimensions, Is a Basic Right H-65.960

1. Our American Medical Association acknowledges that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right.
2. Our AMA acknowledges that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

[Res. 021, A-19; Reaffirmed: Res. 234, A-22]

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

[Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

[Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our American Medical Association advocates for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
    a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
    d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
    e. The public option is financially self-sustaining and has uniform solvency requirements.
    f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
    g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
    a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
    b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
    c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
    d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
    e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
    g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
    h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
    a. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.

b. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
c. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans.

[CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24]

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our American Medical Association will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.

2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.

3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.

4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of:

    a. The health needs of this unique population, including standard pediatric care as well as mental health needs.

    b. Health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals.

    c. The resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals.

    d. Avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

[Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18; Reaffirmed: Res. 210, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-25)

Introduced by: Resident and Fellow Section, American College of Physicians

Subject: Carceral Systems and Practices in Behavioral Health Emergency Care

Referred to: Reference Committee on Ethics and Bylaws

Whereas, law enforcement officers (LEOs) often serve as first responders during behavioral health emergencies (BHEs), including as transport to hospitals[1–4]; and

Whereas, although some LEOs may possess de-escalation skills, effective trainings are not universally implemented, and the mere presence of armed, uniformed officers with police vehicles can exacerbate feelings of distress and escalate BHEs, particularly in communities where relationships with police are characterized by tension and distrust[5]; and

Whereas, individuals with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians[6]; and

Whereas, Black children have a 1.8-times greater odds of being handcuffed during a BHE than white children, with 2.6-times greater odds among Black girls compared to white girls and 1.5-times greater odds in the most disadvantaged neighborhoods compared to the least[7]; and

Whereas, from 2003-2018, compared to white adolescents, Black and Hispanic adolescents had six and three times greater risk of firearm-related mortality due to legal intervention, respectively[8,9]; and

Whereas, the high-profile deaths of individuals like a 15-year-old Black teen with autism who was killed by a deputy responding to a BHE call, have reinvigorated long standing clarion calls to reform BHE response systems[10–12]; and

Whereas, the American Civil Liberties Union has argued that reliance on police creates a disparity between responses to physical and mental health emergencies, thereby discriminating against people with mental health conditions and developmental disabilities[13]; and

Whereas, the U.S. Department of Justice indicated in February 2024 that existing civil rights statutes like the Americans with Disabilities Act “may require dispatching a different type of response to mental health emergencies when appropriate, such as mobile crisis teams staffed with behavioral health professionals, to avoid discrimination on the basis of disability”[14]; and

Whereas, alternatives to carceral BHE responses which prioritize leadership by trained mental health professionals, coordination with community-based services, and compassionate person-centered responses have existed for decades in cities across the U.S. with remarkable efficacy and cost savings[6,12,15–17]; and

Whereas, the 9-8-8 Implementation Act, which our AMA has not yet actively supported despite endorsement from numerous other organized medical societies, would provide federal funding

and guidance for more states to implement crisis response infrastructure which relies on trained mental health specialists instead of armed law enforcement[18]; and

Whereas, our AMA Code of Ethics 1.2.7 is clear that patients should "never be restrained punitively, for convenience, or as an alternative to reasonable staffing",[19] and international human rights standards note that – especially for children and youth – physical restraints "can only be used in exceptional cases, where all other control methods have been exhausted and failed"[20]; and

Whereas, incarcerated youth are often routinely and indiscriminately shackled when seeking emergency mental health care regardless of their safety or elopement risk, which is inconsistent with the rehabilitative goals of the juvenile justice system, our AMA's own Code of Ethics, international human rights standards, and the policy positions of leading public health organizations[21–24]; therefore be it

RESOLVED, that our American Medical Association amend policy H-345.972 (Mental Health Crisis Interventions) by addition and deletion to read as follows:

1. Our American Medical Association continues to support jail diversion and community based treatment options for mental illness.
2. Our AMA advocates for funding and implementation of evidence-based interventions to decouple behavioral health response systems from carceral systems, including but not limited to diverting acute mental illness and social-service related calls to mobile crisis teams staffed by mental health trained professionals rather than solely or primarily relying on armed law enforcement.
   ~~Our AMA supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs.~~
3. Our AMA supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs.
4. Our AMA supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections and law enforcement officers in effectively interacting with people with mental health crises or ~~and~~ other behavioral dysregulation ~~issues~~ in all ~~detention and~~ correctional facilities and communities.
5. Our AMA supports:
   a. increased research on disparate use of force and non-violent de-escalation tactics during ~~for~~ law enforcement encounters with people who have mental illness and/or developmental disabilities.
   b. research on fatal encounters with law enforcement and the prevention thereof (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA support ending routine reliance on law enforcement to triage, evaluate, or transport individuals experiencing behavioral health emergencies and instead support improved funding for Emergency Medical Services to meet communities' needs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against the routine application of physical restraints, including handcuffs, during behavioral health emergency responses or as part of police protocols when transporting non-incarcerated individuals to receive health care services (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate against the indiscriminate shackling of children and adults during prehospital and hospital care, as the use of restraints should be limited to the least restrictive option and only applied when medically necessary (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the Council on Judicial and Ethical Affairs to study this topic to provide clearer guidance for healthcare professionals regarding interacting with law enforcement while caring for patients and the indiscriminate shackling of youth and adults in carceral custody, with particular attention to the removal of shackles in lieu of the least restrictive restraint option. (Directive to Take Action)

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

Received: 04/21/25

REFERENCES

1. Jones N, Gius B, Shields M, et al. Youths' and Young Adults' Experiences of Police Involvement During Initiation of Involuntary Psychiatric Holds and Transport. Psychiatr Serv Wash DC. 2022;73(8):910-917. doi:10.1176/appi.ps.202100263
2. Zoeteman JB, de Wit MAS, de Haas HJ, et al. Coercion During Psychiatric Ambulance Versus Police Transport in Mental Health Crises: A Pre- and Postimplementation Study. Psychiatr Serv Wash DC. Published online May 29, 2024:appips20230571. doi:10.1176/appi.ps.20230571
3. Rosen DL, Travers D. Emergency department visits among patients transported by law enforcement officers. PLoS ONE. 2021;16(1):e0244679. doi:10.1371/journal.pone.0244679
4. Heffernan J, McDonald E, Hughes E, Gray R. Tri-Response Police, Ambulance, Mental Health Crisis Models in Reducing Involuntary Detentions of Mentally Ill People: A Systematic Review. Nurs Rep. 2022;12(4):1004-1013. doi:10.3390/nursrep12040096
5. Jacoby SF, Branas CC, Holena DN, Kaufman EJ. Beyond survival: the broader consequences of prehospital transport by police for penetrating trauma. Trauma Surg Acute Care Open. 2020;5(1):e000541. doi:10.1136/tsaco-2020-000541
6. Fuller DA, Lamb HR, Biasotti M, Snook J. Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters. Treatment Advocacy Center; 2015:1-27. Accessed July 25, 2024. https://www.treatmentadvocacycenter.org/wp-content/uploads/2023/11/Overlooked-in-the-Undercounted.pdf
7. Watkins K, Glomb NW, Trivedi TK, et al. Race, Neighborhood Disadvantage, and Law Enforcement Handcuffing in Prehospital Pediatric Behavioral Health Emergencies. JAMA Netw Open. Published online 2024.
8. Badolato GM, Boyle MD, McCarter R, Zeoli AM, Terrill W, Goyal MK. Racial and Ethnic Disparities in Firearm-Related Pediatric Deaths Related to Legal Intervention. Pediatrics. 2020;146(6):e2020015917. doi:10.1542/peds.2020-015917
9. Gibbs E, Schomberg J, Wallace EL, et al. The role of race in pediatric legal intervention as a cause of injury. J Pediatr Surg. 2022;57(1):158-167. doi:10.1016/j.jpedsurg.2021.09.030
10. Lartey J. Why an Autistic Teen's Death Raises Questions About Police Training. The Marshall Project. March 16, 2024. Accessed July 25, 2024. https://www.themarshallproject.org/2024/03/16/california-police-autism-disability
11. Thompson C. Sending Unarmed Responders Instead of Police: What We've Learned. The Marshall Project. July 25, 2024. Accessed July 25, 2024. https://www.themarshallproject.org/2024/07/25/police-mental-health-alternative-911
12. Contact with Individuals with Autism: Effective Resolutions. Office of Justice Programs; 2001. Accessed July 25, 2024. https://www.ojp.gov/ncjrs/virtual-library/abstracts/contact-individuals-autism-effective-resolutions
13. Bread for the City v. District of Columbia. American Civil Liberties Union. July 6, 2023. Accessed July 25, 2024. https://www.aclu.org/cases/bread-for-the-city-v-district-of-columbia
14. Office of Public Affairs. Justice Department Files Statement of Interest in Lawsuit Concerning Unnecessary Law Enforcement Responses to Mental Health Emergencies. U.S. Department of Justice. February 22, 2024. Accessed July 25, 2024. https://www.justice.gov/opa/pr/justice-department-files-statement-interest-lawsuit-concerning-unnecessary-law-enforcement
15. Waters R. Enlisting Mental Health Workers, Not Cops, In Mobile Crisis Response. Health Aff (Millwood). 2021;40(6):864-869. doi:10.1377/hlthaff.2021.00678
16. Beck J, Reuland M, Pope L. Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses. Vera Institute of Justice; 2020. Accessed September 11, 2024. https://www.vera.org/behavioral-health-crisis-alternatives
17. Scott RL. Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. Psychiatr Serv Wash DC. 2000;51(9):1153-1156. doi:10.1176/appi.ps.51.9.1153
18. Rep. Tony Cárdenas. 9-8-8 Implementation Act of 2023.; 2023. Accessed July 26, 2024. https://www.congress.gov/bill/117th-congress/house-bill/7116
19. Opinion 1.2.7 - Use of Restraints. AMA Code of Medical Ethics. Accessed July 25, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/use-restraints
20. UN General Assembly (45th Session: 1990-1991). United Nations Rules for the Protection of Juveniles Deprived of Their Liberty [Havana Rules]. United Nations; 1991:1-17. Accessed August 4, 2024. https://digitallibrary.un.org/record/105555
21. Campaign Against Indiscriminate Juvenile Shackling. National Juvenile Defender Center; 2016:1-4. Accessed July 26, 2024. https://www.defendyouthrights.org/wp-content/uploads/NJDC_CAIJS_Issue-Brief.pdf
22. Robinson M, Lavere K, Porsa E. End the Routine Shackling of Incarcerated Inpatients. J Hosp Med. 2021;16(6):376-377. doi:10.12788/jhm.3581
23. Haber LA, Pratt LA, Erickson HP, Williams BA. Shackling in the Hospital. J Gen Intern Med. 2022;37(5):1258-1260. doi:10.1007/s11606-021-07222-5

24. APHA Policy Statement 20233 - A Call to Stop Shackling Incarcerated Patients Seeking Health Care. American Public Health Association. November 14, 2023. Accessed July 25, 2024. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2024/01/16/shackling-incarcerated-patients

RELEVANT AMA POLICY

1.2.7 Use of Restraints
All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:
(a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
(b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate:
(i) why restraint is recommended;
(ii) what type of restraint will be used;
(iii) length of time for which restraint is intended to be used.
(c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

Mental Health Crisis Interventions H-345.972
1. Our American Medical Association continues to support jail diversion and community based treatment options for mental illness.
2. Our AMA supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs.
3. Our AMA supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs.
4. Our AMA supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
5. Our AMA supports:
    1. increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities.
    2. research of fatal encounters with law enforcement and the prevention thereof.

[Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22]

Shackling of Pregnant Women in Labor H-420.957
1. Our American Medical Association supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
    - An immediate and serious threat of harm to herself, staff or others.
    - A substantial flight risk and cannot be reasonably contained by other means."

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

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

[Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20; Reaffirmed: CSAPH Rep. 06, A-23]

CMS Interim Final Rule on the Use of Seclusion and Restraints H-280.952

Our AMA uses the following principles in establishing policy regarding restraints and seclusion:
(1) the patient has the right to be free of restraints and seclusion unless medically necessary.
(2) the least restrictive means be considered first.
(3) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.
(4) when a physician is not physically present a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard.

[Sub. Res. 101, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Policing Reform D-65.987

1. Our American Medical Association will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement.
2. Our AMA will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death.
3. Our AMA encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities.
4. Our AMA supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.
5. Our American Medical Association advocates for research to be conducted that examines the public health consequences of negative interactions with police, including the impact on civilians and law enforcement professionals.
6. Our AMA advocates for a change to the U.S. Standard Certificate of Death to include a “check box” that would capture deaths in custody and further categorize the custodial death using cause and manner of death and information from the “How Injury occurred” section of the death certificate.

[BOT Rep. 2, I-21; Appended: Res. 425, A-23]

Policing Reform H-65.954

1. Our American Medical Association recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color.
2. Our AMA will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers.
3. Our AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures.
4. Our AMA will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.
5. Our American Medical Association recognizes the way we police our communities is a social determinant of health.
6. Our AMA advocates for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force.
7. Our AMA supports research on the impact upon employed physicians in law enforcement and the potential risk for exacerbating the physician workforce shortage within correctional medicine if qualified immunity was eliminated.

[Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 431, A-23]

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955

1. Our American Medical Association encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Our AMA encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Our AMA encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

[Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21; Reaffirmed: CSAPH Rep. 4, I-23]

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993

1. Our American Medical Association supports the development of:
    1. Best practices for acute care of patients in the custody of law enforcement or corrections.
    2. Clearly defined and consistently implemented processes between health care professionals and law enforcement that:
        a. can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and
        b. ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and
    3. If conflict arises during an incarcerated individual’s hospitalization that the hospital’s bioethics committee should convene to address the issue and not a law enforcement liaison.
2. Our AMA affirms that:
    1. the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.
    2. it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
2. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.
3. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.

[Res. 407, A-22; Modified: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 4, I-23]

Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting H-130.932

1. Our American Medical Associatio believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated.
2. Our AMA recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.
3. Our AMA is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black

men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.

4. Our AMA opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason.
5. Our AMA recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken.
6. Our AMA encourages the continued use of the necessary and effective dual-response method of communication between law enforcement and EMS to appropriately care for all patients encountered by first responders, including those patients demonstrating agitated or combative behavior.
7. Our AMA calls for comprehensive, independent analysis of law enforcement agencies to:
    a. Review cases labeled as “excited delirium” to determine frequency of use of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors.
    b. Assess the available training and guidelines used to prepare law enforcement first responders to respond to individuals with agitated or combative behavior, including de-escalation training.
    c. Assess efforts to ensure adherence to approved training on an ongoing basis.
8. Our AMA calls for comprehensive, independent analysis, performed by appropriate medical and behavioral health professionals, of EMS agencies to:
    a. Review the usage of ketamine and other sedative-hypnotic medications used to sedate patients with agitated or combative behavior and correlation of the tern “excited delirium” with race, ethnicity, gender, age or other demographic factors.
    b. Assess whether existing training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
        i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting.
        ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications.
        iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers.
    c. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training.
9. Our AMA urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training, overseen by EMS medical directors. The training should minimally include de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting.
10. Our AMA urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.

[CSAPH Rep. 2, A-21; Appended: BOT Action in response to referred for decision: CSAPH Rep. 2, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-25)

Introduced by: Senior Physicians Section

Subject: Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the American Medical Association Senior Physicians Section is concerned that a withdrawal from the World Health Organization (WHO) poses a threat to the health of United States of America citizens by limiting access to information on emerging infections in WHO member countries[1,2,3,4,5]; and

Whereas, the United States Agency for International Aid (USAID), a Congressional authorized agency, has had its funds and staff suspended, making it difficult to continue providing life-saving health programs in developing countries for disease outbreaks and epidemics for seniors[6,7]; and

Whereas, it is critical for the U.S. to remain a global leader in public health in order to protect the interests of Americans and provide continued guidance on reforms that enhance accountability and cost-effectiveness within international organizations, which in turn strengthens America's leadership role; and

Whereas, the United States Agency for International Development (USAID) works in many areas, including agriculture, economic growth, education, democracy, human rights, governance, and the environment to promote prosperity, democracy, and security worldwide[8]; therefore be it

RESOLVED, that our American Medical Association opposes withdrawal from the World Health Organization (WHO) as a continued public health threat to the U.S population by limiting early access to evolving worldwide epidemics (Directive to Take Action); and be it further

RESOLVED, that our AMA opposes any cuts to USAID (United States Agency for International Development) programs that increase the risk of infection among vulnerable populations, including senior citizens, or that withhold funding from critical initiatives supporting agriculture, economic development, environmental protection, education, democracy, human rights, and governance in developing countries. (Directive to Take Action)

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

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REFERENCES

1. Kaiser Family Foundation. (2023, January 23). *10 things to know about U.S. funding for global health*. https://www.kff.org/global-health-policy/issue-brief/10-things-to-know-about-u-s-funding-for-global-health/
2. World Health Organization. (2025). Preparing and preventing epidemics and pandemics. Accessed on February 19, 2025, Preparing and preventing epidemics and pandemics

3. Park, A. (2025, February 19). *What leaving the WHO means for the U.S. and the world.* Time Magazine. What Leaving the WHO Means for the U.S and the World | TIME
4. Edwards, C. (2025, January 21). *What is the World Health Organization and why does Trump want to leave it?* . What is the World Health Organization and why does Trump want to leave it? | CNN
5. Richter, F. (2025, January 21). The U.S. Is the Largest Contributor to the WHO. Statista Website. https://www.statista.com/chart/33800/top-contributors-to-the-world-health-organization/
6. Hernandez, J. (2025, February 3). *What is USAID, the U.S. Agency for International Development.* Explainer: What is USAID and what does it do?: NPR
7. Chuck, E. (2025, February 3). *What is USAID? How it works and what could happen if Trump and Musk shut it down*. https://www.nbcnews.com/news/us-news/what-is-usaid-trump-musk-shut-down-budget-funding-doge-rcna190441
8. United States Agency for International Development (USAID): Economic Growth, Education, Health, Democracy, Environment, Humanitarian Aid. Accessed February 17, 2025, https://www.usaid.gov/

RELEVANT AMA POLICY

G-630.070 International Strategy

1. Our American Medical Association recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship.
2. Our AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations.
3. Our AMA:
    a. continues to support the World Health Organization as an institution.
    b. advocates full funding as understood by the United States Government for the World Health Organization.
    c. will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization.
    d. encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.
4. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO.
5. Our AMA will include the International Medical Graduates Section as a resource for international medical initiatives.
6. Our AMA will:
    a. continue to focus its international activities on and through organizations that are multinational in scope.
    b. encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world.
    c. encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world.
    d. work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities.
    e. work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods.
    f. communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives.
7. Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

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