AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee on Ethics and Bylaws

John Maa, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 18 - Physician Assisted Suicide
3. BOT Report 28 - Specialty Society Representation in the House of Delegates – Five-Year Review
4. CCB Report 02 - Concurrent Service on Councils and Section Governing Councils
5. CEJA Report 01 - The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance
6. CEJA Report 02 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
7. CEJA Report 05 - Protecting Physicians Who Engage in Contracts to Deliver Health Care Services
8. CEJA Report 06 - Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
9. *CEJA Report 09 - Ethical Impetus for Research in Pregnant and Lactating Individuals
10. CEJA Report 10 - The Preservation of the Primary Care Relationship
11. CEJA Report 11 - CEJA Sunset Review of 2015 House Policies
12. *CEJA Report 13 - Presumed Consent & Mandated Choice for Organs from Deceased Donors
13. Resolution 003 - Opposition to Censorship in Public Libraries
14. Resolution 005 - Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
15. Resolution 007 - Use of Inclusive Language in AMA Policy
16. Resolution 008 - Humanism in Anatomical Medical Education
17. Resolution 009 - Patient Centered Health Care as a Determinant of Health
18. Resolution 014 - Protecting Access to Emergency Abortion Care Under EMTALA
19. Resolution 015 - Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems

RECOMMENDED FOR ADOPTION AS AMENDED

20. BOT Report 26 - Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
21. CCB Report 03 - Clarifying Bylaw Language
22. Resolution 001 - Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments

23. *Resolution 004 - Reducing the Harmful Impacts of Immigration Status on Health
24. *Resolution 006 - Military Deception as a Threat to Physician Ethics
25. Resolution 010 - Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
26. Resolution 011 - Opposition of Health Care Entities from Reporting Individual Patient Immigration Status
27. Resolution 012 - Carceral Systems and Practices in Behavioral Health Emergency Care
28. Resolution 013 - Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

RECOMMENDED FOR REFERRAL

29. *CCB Report 01 - Bylaws Review Report
30. CEJA Report 07 - Guidelines on Chaperones for Sensitive Exams
31. *CEJA Report 08 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation

RECOMMENDED FOR NOT ADOPTION

32. Resolution 002 - Physician Disclosures of Relationships in Private Equity Held Organizations

If you wish to propose an amendment to an item of business, click here:
Submit New Amendment

*Your Reference Committee recommendation has changed from the Preliminary Report.

RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 02 be <u>adopted</u> and the remainder of the report be <u>filed.</u>

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)

Online testimony was in unanimous support of the report. In-person testimony was minimal and in unanimous support of the report. Your Reference Committee recommends that the report be adopted.

(2) BOT REPORT 18 - PHYSICIAN ASSISTED SUICIDE

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 18 be <u>adopted</u> and the remainder of the report be <u>filed.</u>

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.

The voluminous online testimony was generally in support of the report. In-person testimony was also largely in support of the report as written. In-person testimony proffered an amendment to strike the word “legally.” Both online and in-person testimony did not support the amendment. CEJA testified that removing the word “legally” would cause a conflict with the *Code* and recommended that the language not be amended.

Additional testimony was offered to amend existing policy; however, the Speaker of the House testified that such policies cannot be amended in this way. Your Reference Committee recommends that the report be adopted.

(3) BOT 28 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that BOT 28 be adopted and the remainder of the report be filed.

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

1. The American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American Association of Plastic Surgeons, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Breast Surgeons, American Society of Cytopathology, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Vein and Lymphatic Society and Society of Hospital Medicine be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

There was no online testimony due to this resolution being submitted in the tote. In-person testimony was limited and in unanimous support. Your Reference Committee recommends that the report be adopted.

(4) CCB REPORT 02 - CONCURRENT SERVICE ON COUNCILS AND SECTION GOVERNING COUNCILS

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 02 be adopted and the remainder of the report be filed.

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)

Online testimony was in unanimous support of the report. The limited in-person testimony was in support, with one proffered amendment to include the AMA Foundation and AMPAC. CCB reviewed with legal counsel and testified that our AMA should not name separate corporate entities in the bylaws and are against the amendment. Your Reference Committee recommends that the report be adopted.

(5) CEJA REPORT 01 - THE AMA CODE OF MEDICAL ETHICS EVOLVING TO PROVIDE HEALTH CARE SYSTEMS ETHICS GUIDANCE

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 01 be <u>adopted</u> and the remainder of the report be <u>filed.</u>

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.

Online testimony was mixed. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(6) CEJA REPORT 02 - SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE ACTIONS AND/OR UNIONIZATION

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 02 be <u>adopted</u> and the remainder of the report be <u>filed.</u>

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:
<u>Advocacy and Collective Actions by Physicians</u> ~~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<u>, or practice</u> are contrary to the best interests of patients. However, <u>advocacy actions should not put the wellbeing of patients in jeopardy.</u>

<u>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</u>

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)

Online testimony was in general support of the report. In-person testimony was in strong support. Your Reference Committee recommends that the report be adopted.

(7) CEJA REPORT 05 - PROTECTING PHYSICIANS WHO ENGAGE IN CONTRACTS TO DELIVER HEALTH CARE SERVICES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 05 be adopted and the remainder of the report be filed.

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.

(Modify HOD/CEJA Policy)

Online testimony was in unanimous support of the report. In-person testimony was mixed, with a majority in favor of the report. Testimony in opposition highlighted the need for further AMA policy to address physician contracts with private equity firms. In consideration of the online and in-person testimony, your Reference Committee recommends that the report be adopted.

(8) CEJA REPORT 06 - AMENDMENT TO OPINION 1.1.1 "PATIENT-PHYSICIAN RELATIONSHIPS"

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 06 be adopted and the remainder of the report be filed.

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)

Online testimony was in unanimous support of the report. In-person testimony was generally in favor of referral out of concern that the report does not address "political and administrative influence." Although these issues were raised, these concerns are addressed by several *Code of Medical Ethics* Opinions, including 1.1.3, 1.1.6, 1.2.10, 3.1.1, 3.1.2, 3.2.1, 10.6, 11.1.1, 11.1.4, 11.2.1, & 11.2.2. Your Reference Committee recommends that the report be adopted.

(9) *CEJA REPORT 09 - ETHICAL IMPETUS FOR RESEARCH IN PREGNANT AND LACTATING INDIVIDUALS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 09 be adopted and the remainder of the report be filed.

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

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

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

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

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

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

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

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

(e) Ensure risks to the fetus or nursing infants are not greater than minimal, especially

when the intervention under study is not intended primarily to benefit the fetus or infant, but rather for the development of important biomedical knowledge that cannot be obtained by any other means.

2. Policy D-140.949 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Online testimony was in strong support. In-person testimony recommended referral. One delegation changed their initial online support to referral, calling for language in the report to state that researchers must explain why pregnant and lactating individuals should be automatically excluded from research. However, your Reference Committee notes that this language is already included in this report. Your Reference Committee recommends that the report be adopted.

(10) CEJA REPORT 10 - THE PRESERVATION OF THE PRIMARY CARE RELATIONSHIP

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 10 be <u>adopted</u> and the remainder of the report be <u>filed.</u>

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

Online testimony was in unanimous support of the report. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(11) CEJA REPORT 11 - CEJA'S SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 11 be adopted and the remainder of the report be filed.

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

Online testimony was in unanimous support. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(12) *CEJA REPORT 13 - PRESUMED CONSENT & MANDATED CHOICE FOR ORGANS FROM DECEASED DONORS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 13 be adopted and the remainder of the report be filed.

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

Online testimony was in unanimous support of the report. Limited in-person testimony was mixed. Your Reference Committee recommends that the report be adopted.

(13) RESOLUTION 003 - OPPOSITION TO CENSORSHIP IN PUBLIC LIBRARIES

RECOMMENATION:

Your Reference Committee recommends that Resolution 003 be <u>adopted.</u>

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 <u>and Libraries</u>, 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, <u>or public libraries</u>.

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)

Online testimony was in unanimous support. In-person testimony was in strong support. Your Reference Committee recommends that the resolution be adopted.

(14) RESOLUTION 005 - DEDICATED INTERFAITH PRAYER AND REFLECTION SPACES IN MEDICAL SCHOOLS AND HEALTHCARE FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 005 be <u>adopted.</u>

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)

Online testimony was in unanimous support. In-person testimony was in general support. Testimony in opposition raised concerns about costs and feasibility. Your Reference Committee recommends that the resolution be adopted.

(15) RESOLUTION 007 - USE OF INCLUSIVE LANGUAGE IN AMA POLICY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 007 be <u>adopted.</u>

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)

Online testimony was in unanimous support. In-person testimony was generally in favor, with an amendment proffered without additional support. Your Reference Committee recommends that the resolution be adopted.

(16) RESOLUTION 008 - HUMANISM IN ANATOMICAL MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 008 be <u>adopted.</u>

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)

Online testimony was in unanimous support. In-person testimony was mixed with opposition suggesting possible reaffirmation; however, the proposed resolution is not addressed by current AMA policy and thus reaffirmation is not applicable. Your Reference Committee recommends that the resolution be adopted.

(17) RESOLUTION 009 - PATIENT CENTERED HEALTH CARE AS A DETERMINANT OF HEALTH

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be <u>adopted.</u>

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)

Online testimony was in strong support of the resolution. In-person testimony was in unanimous support. Your Reference Committee recommends that the resolution be adopted.

(18) RESOLUTION 014 - PROTECTING ACCESS TO EMERGENCY ABORTION CARE UNDER EMTALA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 014 be <u>adopted.</u>

RESOLVED, that our American Medical Association reaffirm policy D-5.999 Preserving Access to Reproductive Health Services (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocate for the reinstatement of federal guidance affirming hospitals' obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion restrictions (Directive to Take Action); and be it further

RESOLVED, that our AMA support legal and policy measures that protect physicians and other healthcare providers from criminal, civil, or professional repercussions when providing necessary emergency pregnancy care, including, but not limited to, abortion care, required under EMTALA (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care (Directive to Take Action); and be it further

RESOLVED, that our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," provide ongoing 93 recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care. (Directive to Take Action)

There was no online testimony due to this resolution being submitted in the tote. In-person testimony was in unanimous support with mention of the importance of the Supremacy Clause in the US Constitution regarding conflicts between state and federal laws. Testimony also conveyed the urgency of this resolution due to ongoing risks to patient health and an evolving legal landscape that place physicians in a position of choosing between upholding ethical standards or the law. Your Reference Committee recommends the resolution be adopted.

(19) RESOLUTION 015 - ADDRESSING TARGETING AND WORKPLACE RESTRICTIONS AND BARRIERS TO HEALTHCARE DELIVERY BY INTERNATIONAL MEDICAL GRADUATE (IMG) PHYSICIANS AND OTHER PHYSICIANS BASED UPON MIGRATION STATUS OR COUNTRY OF ORIGIN WITHIN HEALTHCARE SYSTEMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 015 be <u>adopted.</u>

RESOLVED, that our American Medical Association work with relevant stakeholders to develop model workplace policies to address unfair treatment or targeting of physicians and other healthcare workers, based upon migration status or country of origin, during the regular performance of their duties within healthcare systems (Directive to Take Action); and be it further

RESOLVED, that our AMA study and develop model hospital and workplace policies to provide standardized procedures for addressing situations in which U.S. Immigration and Customs Enforcement (ICE) officers seek entry into “protected areas,” such as hospitals and healthcare settings to produce actions which may impact patient care or physician safety. (Directive to Take Action)

There was no online testimony as this resolution was placed in the tote. In-person testimony was in unanimous support. Your Reference Committee recommends that the resolution be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(20) BOT REPORT 26 - USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

RECOMMENDATION A:

Your Reference Committee recommends that BOT 26 be amended by addition of a new third recommendation as follows:

> **3. Any entity that collects physician personal health information or biological data must have transparent policies and procedures for secure data storage as well as its storage duration and deletion protocols.**

RECOMMENDATION B:

That BOT 26 be adopted as amended and the remainder of the report be filed.

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.

Online testimony was in support of adoption with minor amendments. In-person testimony was mixed, with a majority in favor of adoption as amended. Your Reference Committee recommends that the report be adopted as amended.

(21) CCB REPORT 03 - CLARIFYING BYLAW LANGUAGE

RECOMMENDATION A:

Your Reference Committee recommends that section 2.1.1. of CCB Report 03 be amended by addition and deletion as follows:

> **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.**

RECOMMENDATION B:

Your Reference Committee recommends that section 6.5.3.1 of CCB Report 03 be amended by addition and deletion as follows:

> **6.5.3.1 All questions involving membership as provided in the 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~~.**

RECOMMENDATION C:

That CCB 03 Report 03 be adopted as amended and the remainder of the report be filed.

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 Membership.

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 UnitedStates 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.

****

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. 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~~.

***

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)

Online testimony was in unanimous support of adoption of the report with proffered amendments for clarity and consistency. During in-person testimony, the authors offered an additional amendment for clarity and consistency, which received unanimous support. Your Reference Committee recommends that the report be adopted as amended.

(22) RESOLUTION 001 - OPPOSITION TO CENSURING MEDICAL SOCIETIES OR ORGANIZATIONS BASED ON POLITICS OR POLICIES OF GOVERNMENTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 001 be amended by <u>addition and deletion</u>:

> **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~~,~~ <u>of its host government</u> ~~such that the art and science of medicine is kept separate from politics~~. (Directive to Take Action)**

RECOMMENDATION B:

That Resolution 001 be <u>adopted as amended.</u>

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)

Online testimony was generally in favor of adoption, with a minor amendment proffered. Limited in-person testimony was unanimously in favor of adoption as amended. Your Reference Committee recommends that the resolution be adopted as amended.

(23) *RESOLUTION 004 - REDUCING THE HARMFUL IMPACTS OF IMMIGRATION STATUS ON HEALTH

RECOMMENDATION A:

That the second resolve of Resolution 004 be amended by addition as follows:

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

RECOMMENDATION B:

That Resolution 004 be adopted as amended.

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)

Online testimony was in unanimous support. In-person testimony was in strong support. An amendment was proffered and accepted by the authors. Your Reference Committee recommends that the resolution be adopted as amended.

(24) *RESOLUTION 006 - MILITARY DECEPTION AS A THREAT TO PHYSICIAN ETHICS

RECOMMENDATION A:

That the title of Resolution 006 be amended by deletion as follows:

~~Military~~ Deception as a Threat to Physician Ethics.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 006 be adopted as amended.

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)

Online testimony was in unanimous support. In-person testimony was in general support. An amendment was proffered and accepted by the authors. Your Reference Committee recommends that the resolution be adopted as amended.

(25) RESOLUTION 010 - MANAGING CONFLICT OF INTEREST INHERENT IN NEW PAYMENT MODELS—PATIENT DISCLOSURE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve clause of Resolution 010 be deleted.

> **~~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~~**

RECOMMENDATION B:

That Resolution 010 be adopted as amended.

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).

Online testimony was in general support of the resolution with an amendment that the first resolve clause be deleted. During in-person testimony, the authors testified in support of the amendment; no other in-person testimony was offered. Your Reference Committee recommends that the resolution be adopted as amended.

(26) RESOLUTION 011 - OPPOSITION OF HEALTH CARE ENTITIES FROM REPORTING INDIVIDUAL PATIENT IMMIGRATION STATUS

RECOMMENDATION A:

Your Reference Committee recommends that the added subsection to Policy H-440.876 be further amended by addition as follows:

d. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status.

RECOMMENDATION B:

That Resolution 011 be adopted as amended.

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)

Online testimony was in unanimous support. An amendment was proffered for consistency and clarity to recognize that the institutions mentioned refer to health care institutions. In-person testimony was in universal support of adoption as amended. Your Reference Committee recommends that the resolution be adopted as amended.

(27) RESOLUTION 012 - CARCERAL SYSTEMS AND PRACTICES IN BEHAVIORAL HEALTH EMERGENCY CARE

RECOMMENDATION A:

Your Reference Committee recommends that subsection 5(a) of Policy H-345.972 be amended by addition and deletion as follows:

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.

RECOMMENDATION B:

That the fourth resolve of Resolution 012 be amended by addition as follows:

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 or necessary for the safety of the healthcare team (Directive to Take Action); and be it further

RECOMMENDATION C:

That the fifth resolve of Resolution 012 be amended by deletion as follows:

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~~.

RECOMMENDATION D:

That Resolution 012 be adopted as amended.

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)

Online testimony was in general support, with minor amendments proffered. In-person testimony was in unanimous support of the resolution as amended, with an additional amendment proffered by CEJA and accepted by the author. Your Reference Committee recommends that the resolution be adopted as amended.

(28) RESOLUTION 013 - CONTINUED SUPPORT OF WORLD HEALTH ORGANIZATION (WHO) & UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 013 be amended by <u>addition and deletion</u> as follows:

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

RECOMMENDATION B:

That Resolution 013 be <u>adopted as amended.</u>

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)

Online testimony was in strong support of the resolution, with proffered amendments citing the need to recognize that the WHO does valuable work related to disabilities and not just infectious diseases, and that a broader definition of vulnerable populations is needed. In-person testimony was in unanimous support of the amended resolution. Your Reference Committee recommends that the resolution be adopted as amended.

RECOMMENDED FOR REFERRAL

(29) *CCB REPORT 01 – BYLAWS REVIEW REPORT

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 01 be referred.

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 ~~4f~~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)

Online testimony was mixed regarding whether to adopt the report as written or adopt it with a proffered amendment. In-person testimony was mixed. An amendment was proffered, though there was testimony regarding whether to amend, refer, adopt, or not adopt the report. Testimony in favor of amendment held that the proposed language conflicts with the current selection process and creates a burdensome timeline. Testimony in support of the report as written highlighted that this is meant to create congruency within the bylaws. Due to the strongly conflicting testimony, your Reference Committee recommends the report be referred.

(30) CEJA REPORT 07 - GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 07 be referred.

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)

Online testimony was generally in favor of referral. In-person testimony was strongly in favor of referral to address a multitude of different challenges, such as conflicting state laws and policies, patient distrust and refusal, economic sustainability, and varying clinical scenarios. Your Reference Committee recommends that the report be referred.

(31) *CEJA REPORT 08 - LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLINDED MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION:

That CEJA Report 08 be referred.

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)

Online testimony was in unanimous support of the report. In-person testimony was offered by groups that had previously testified online in support to move for referral, citing that the language “clinically relevant” created a “loophole” that weakened the purpose of the report. Your Reference Committee recommends that the report be referred.

RECOMMENDED NOT FOR ADOPTION

(32) RESOLUTION 002 - PHYSICIAN DISCLOSURES OF RELATIONSHIPS IN PRIVATE EQUITY HELD ORGANIZATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 002 be <u>not adopted.</u>

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)

Online testimony was in general opposition to the resolution. Limited in-person testimony was unanimously in support of not adopting the resolution. Your Reference Committee recommends that the resolution be not adopted.

Madam Speaker, this concludes the report of Reference Committee on Ethics and Bylaws. I would like to thank Dr. Rose Berkun, Dr. Mary Campagnolo, Dr. Stuart Glassman, Dr. Brady Iba, Dr. Leslie Secrest, and Dr. Clarence Chou and all those who testified before the committee.

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