

AMERICAN MEDICAL ASSOCIATION WOMEN PHYSICIANS SECTION

Resolution: (Assigned by HOD)
(A-25)

Introduced by: Varudhini Reddy

Subject: Artificial Intelligence in Healthcare: Protecting the Rights of Children

Referred to: Reference Committee (Assigned by HOD)

Whereas, according to current research, there is a lack of a formal global privacy framework for pediatric patient data security and privacy in artificial intelligence (AI) due to the unique challenges of protecting sensitive pediatric patient data. As well, worldwide inconsistency in data protection laws range from highly stringent regulations to nonexistent which complicates the potential benefits of AI that rely on analyzing large amounts of data^{1,3,4,5,8}; and

Whereas, the World Health Organization (WHO) actively works to integrate AI into healthcare systems to maximize benefits and minimize risks, pediatric patient privacy still poses unique challenges and requires specialized attention^{6,7}; and

Whereas, the American Academy of Pediatrics (AAP) acknowledges that AI in pediatric healthcare can reduce costs and physician workloads and improve patient outcomes, the AAP stresses the importance of pediatric patient data security and privacy, the need for clear guidelines, increased monitoring strategies and engagement with relevant stakeholders (AI developers) and end users (parents, children, healthcare providers)^{1,3,8}; and

Whereas, the use of AI in border enforcement such as at the US southern border places pediatric patients and their mothers in vulnerable situations which subject them to trauma, stress, and potentially violate their human rights and access to essential resources²; and

Whereas, AI developers need to be educated on the ethical implications of AI in pediatric care to ensure data privacy and security in order to protect both patients and their parents^{1,3,4,5,7}; and

Whereas, the ownership of pediatric data still remains ambiguous with no consensus on whether it belongs to pediatric patients, parents, providers, researchers, and/or other stakeholders like AI developers. Children's data like images may be at risk for exploitation, for example, shared with third parties, which could follow them throughout their lives^{1,4,5}; and

Whereas, AI-driven monitoring, profiling, and decision-making by certain authorities like healthcare providers or AI developers could infringe on pediatric patient privacy and autonomy including in cases involving CPS. It is necessary to prioritize privacy and consent within pediatric care and further research must be undertaken to address challenges behind these issues^{2,5,8}; and

Whereas, AI-based clinical algorithms may influence decision-making in pediatric care, leading to potentially discriminatory outcomes and there is a lack of clinical oversight (by a licensed healthcare provider)^{1,3,4}; and

Whereas, AI used in border enforcement can exacerbate existing racial, gender, and age discrimination and deny migrants including mothers and children access to resources and opportunities that others may receive²; therefore be it

RESOLVED, that our American Medical Association advocates for further research into the unique challenges of using artificial intelligence in pediatric care and supports the continued development of evolving guidelines to ensure the ethical use of AI in order to protect pediatric patient privacy, human rights, and prevent exploitation; and be it further

RESOLVED, that our AMA calls for increased engagement and collaboration from end users such as pediatric patients and their families, healthcare providers, policy makers in the development, deployment, and use of AI technologies along with AI developers to ensure safety and equity to serve the best interests of pediatric populations; and be it further

RESOLVED, that our AMA explores the concept of ownership and informed consent guidelines for pediatric data to reveal the risks of data exploitation and ensure that end users retain control over sensitive personal information at the moment and throughout their lives; and be it further

RESOLVED, that our AMA advocates for increased research on the ethical implications of a global privacy framework for patient data and artificial intelligence for vulnerable populations such as mothers and children. We emphasize the need for assessing cross-border risks while prioritizing data privacy and protection for vulnerable populations.

Fiscal Note: (Assigned by HOD)

Received: XX/XX/2025

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of **augmented intelligence** (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
 - a. clinical validation.
 - b. alignment with clinical decision-making that is familiar to physicians.
 - c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
 - a. be informed by real world workflow and human-centered design principles.
 - b. enable physicians to prepare for and transition to new care delivery models.
 - c. support effective communication and engagement between patients, physicians, and the health care team.
 - d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
 - e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
 - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
 - b. The imposition of costs associated with acquisition, implementation, and maintenance of **healthcare** AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
 - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
 - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
 - a. Identify areas of medical practice where AI systems would advance the quadruple aim.
 - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
 - c. Outline new professional roles and capacities required to aid and guide health care AI systems.
 - d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human **intelligence** and the patient-physician relationship rather than replace it.

[BOT Rep. 21, A-19 Reaffirmation: A-22]

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

[BOT Rep. 41, A-18 Reaffirmed: CMS Rep. 07, A-24]

Use of Augmented Intelligence for Prior Authorization D-480.956

Our American Medical Association advocates **for** greater regulatory oversight **of** the **use of augmented intelligence** for review **of** patient claims and **prior authorization** requests, including whether insurers are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise **for** the service under review.
3. requires such reviews include human examination **of** patient records **prior** to a care denial.

[Res. 721, A-23]

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935

1. Our American Medical Association will study **and** develop recommendations on **the** benefits **and** unforeseen consequences to **the** medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), **and** other augmented intelligence-generated medical advice or content, **and** that our AMA propose appropriate state **and** federal regulations with a report back at A-24.
2. Our AMA will work with **the** federal government **and** other appropriate organizations to protect patients from false or misleading **AI**-generated medical advice.
3. Our AMA will encourage physicians to educate our patients about **the** benefits **and** risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups **and** scientific journals to establish guidelines to regulate **the** use of augmented intelligence in scientific publications that include detailing **the** use of augmented intelligence in **the** methods, exclusion of augmented intelligence systems as authors, **and the** responsibility of authors to validate **the** veracity of any text generated by augmented intelligence.

[Res. 247, A-23]

Augmented Intelligence in Medical Education H-295.857

Our AMA encourages:

- (1) accrediting and licensing bodies to study how AI should be most appropriately addressed **in** accrediting and licensing standards;
 - (2) **medical** specialty societies and boards to consider production of specialty-specific educational modules related to AI;
 - (3) research regarding the effectiveness of AI instruction **in medical education** on learning and clinical outcomes;
 - (4) institutions and programs to be deliberative **in** the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated **in** order to accommodate new training modules;
 - (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent **in** AI systems;
 - (6) the study of how differences **in** institutional access to AI may impact disparities **in education** for students at schools with fewer resources and less access to AI technologies;
 - (7) enhanced training across the continuum of **medical education** regarding assessment, understanding, and application of data **in** the care of patients;
 - (8) the study of how disparities **in** AI educational resources may impact health care disparities for patients **in** communities with fewer resources and less access to AI technologies;
 - (9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters **in** order to assist learners **in** their understanding and use of AI; and
 - (10) close collaboration with and oversight by practicing physicians **in** the development of AI applications.
- [CME Rep. 04, A-19]

11.2.1 Professionalism in Health Care Systems

Containing costs, promoting high-quality **care** for all patients, and sustaining physician **professionalism** are important goals. Models for financing and organizing the delivery of **health care** services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, **health care** organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient. Structures that influence where and by whom **care** is delivered—such as accountable **care** organizations, group practices, **health** maintenance organizations, and other entities that may emerge **in** the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow **health care** professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians **in** leadership positions within **health care** organizations and the profession should:

- (a) Ensure that decisions to implement practices or tools for organizing the delivery of **care** are transparent and reflect input from key stakeholders, including physicians and patients.
- (b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician **professionalism**.
- (c) Ensure that all such tools:
 - (i) are designed **in** keeping with sound principles and solid scientific evidence.
 - a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.
 - b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed **in** keeping with ethics guidance.
 - c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated **in** relevantly similar populations of patients and **care** settings.

- (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate **health care** disparities;
 - (iii) are implemented **in** conjunction with the infrastructure and resources needed to support high-value **care** and physician **professionalism**;
 - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient **care** decisions and the overall financial risk for individual physicians.
 - (d) Encourage, rather than discourage, physicians (and others) to:
 - (i) provide **care** for patients with difficult to manage medical conditions;
 - (ii) practice at their full capacity, but not beyond.
 - (e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
 - (f) Ensure that the use of financial incentives and other tools is routinely monitored to:
 - (i) identify and address adverse consequences;
 - (ii) identify and encourage dissemination of positive outcomes.
- All physicians should:
- (g) Hold physician-leaders accountable to meeting conditions for **professionalism in health care systems**.
 - (h) Advocate for changes **in** how the delivery of **care** is organized to promote access to high-quality **care** for all patients.
- [Issued: 2016 Amended: 2021 Amended: 2022]

2.2.1 Pediatric Decision Making

E-2.2.1, Pediatric Decision Making

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

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

For health care decisions involving minor patients, physicians should:

- (a) Provide compassionate, humane care to all **pediatric** patients.
- (b) Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- (c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- (d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- (e) Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with

similar decisions and have volunteered their support as peers.

(f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in **decision making** in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.

(g) When it is not clear whether a specific intervention promotes the patient's interests, respect the **decision** of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.

(h) When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

[Issued: 2016 Amended: 2019]