OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Rebecca Brendel, MD, Chair:

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

CEJA Opinion; No reference committee hearing.

HOUSE ACTION: FILED

At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 01-I-25, "Amendment to Opinion 1.1.1 "Patient-Physician Relationships." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-1.1.1 – Patient-Physician Relationships

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship 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 responsibilities 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. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.
>
> A patient-physician relationship commences when a physician begins to serve a patient's medical needs. The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include 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. (I, II, III, V, VI, VIII, IX)

2. RESEARCH INVOLVING PREGNANT AND LACTATING INDIVIDUALS

CEJA Opinion; No reference committee hearing.

HOUSE ACTION: FILED

At the 2025 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 03-I-25, "Ethical Impetus for Research in Pregnant and Lactating Individuals." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

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E-7.3.4.1 Research Involving Pregnant and Lactating Individuals

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 must obtain the informed, voluntary consent of pregnant or lactating individuals, and adhere to general principles for ethical conduct of research as in all human participant's research. In addition, physicians conducting research should:

(a) Include pregnant and lactating individuals in research for which they would otherwise be eligible in order to establish a greater knowledge base, produce relevant data, and promote respect for individuals.

(b) Consider excluding pregnant and lactating individuals only when a study poses a substantial risk of significant harm to them or their fetuses or nursing infants, and:

    i. specify why the research excludes pregnant and lactating individuals;

    ii. seek alternative research methodologies to rectify gaps in knowledge.

(c) Where scientifically appropriate and available, base studies that include pregnant and lactating individuals on well-designed, ethically sound, existing research with nonhuman animals or nongravid human participants to better assess potential risks.

(d) Minimize risks to the fetus or nursing infant to the greatest extent possible, especially when the research is not conducted primarily to investigate potential benefit for fetuses or nursing infants, but rather for the development of important biomedical knowledge that cannot be obtained by any other means. (I, III, V)

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* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Rebecca Brendel, MD, Chair:

1. GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: REFERRED

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

> Our American Medical Association will ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in the *Code of Medical Ethics*," to ensure that it is most in line with the current best practices for adult and pediatric populations and potentially considers the following topics:
>
> a. Opt-out chaperones for breast, genital, and rectal exams.
> b. Documentation surrounding the use or not-use of chaperones.
> c. Use of chaperones for patients without capacity.
> d. Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
> e. Use of chaperone at physician request when physician deems necessary.

To fulfil this directive, the Council on Ethical and Judicial Affairs (CEJA) submitted Report 7, "Guidelines on Chaperones for Sensitive Exams," for consideration at the 2025 Annual Meeting. The report was referred with concerns expressed that the report did not adequately address certain issues such as physician safety, the economic hurdles of training and staffing chaperones, and challenges related to varying clinical scenarios, such as those posed by rural hospitals. This report includes recommendations that address these concerns.

BACKGROUND

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

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

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

In most instances, only an authorized member of the health care team should serve as a chaperone and understand the responsibilities of the role. Broadly speaking, chaperones should be provided with information regarding[18]:

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

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

The standard approach is to have healthcare staff (such as nurses, medical assistants or physician assistants) act as chaperones, provided they are fully trained in the responsibilities of the role. Occupying a dual role as chaperone and member of the care team is acceptable when the two sets of responsibilities do not conflict and are well understood by everyone involved. “Parents and other untrained individuals” should not act as chaperones, except in the case of young children[3,17].

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

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

ETHICS ISSUES

The ethical concerns related to the use of chaperones for sensitive examinations center around the trust and trustworthiness of the patient-physician relationship. The use of a chaperone is meant to uphold respect for patients as persons and is intended as a means to recognize and protect patients’ dignity, vulnerability, and autonomy. Chaperones are also important for minimizing risks to physicians as well, such as verbal or physical harassment. In addition to concerns for patient and physician safety, the need for chaperones raises other ethical concerns, such as how to appropriately train, fund, and staff chaperones. This can be particularly challenging in limited resource settings, such as rural hospitals, highlighting that ethical necessities may at times conflict with practical realities, and that the need for a chaperone is always contextually situated, making it difficult to establish clinical guidance that is able to cover all possible scenarios.

DISCUSSION

Medical examinations and procedures often require the patient to put aside their norms regarding modesty and give consent to being heard, seen, and touched in ways they would not usually allow. Therefore, it is critical to show respect to patients and foster trustworthiness. The presence of a chaperone reinforces the professional nature of the clinical interaction, with the goal of providing reassurance that the patient’s experiences and concerns and the boundaries of the clinical encounter are being respected[1]. Having chaperones present can also help prevent misunderstandings

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between patients and physicians by clarifying expectations and facilitating communication about the examination. Chaperones should be familiar with the elements of sensitive examinations and procedures, know how to properly observe them, and know when to intervene if they have concerns. When used in this manner, chaperones may augment a patient's sense of safety by assuring the patient that the interventions are appropriate. Additionally, having a third-party present who can attest to what occurred during the encounter may protect physicians from false allegations of misconduct[1].

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

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

- An opt-in policy is one in which patients are *automatically offered* a chaperone for sensitive examinations and procedures (the patient is informed that they can request a chaperone).
- An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive examinations and procedures (the patient is provided a chaperone, though the patient is given the option to decline, so long as the physician agrees a chaperone is not needed).
- A mandatory policy is one in which a chaperone must be present during all sensitive examinations or procedures, or else the examination or procedure will not be performed.

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

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

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice regarding the presence of a chaperone[13]. Under ordinary circumstances, remaining silent should not be understood as valid consent.

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

Documentation of Chaperone Use

Regardless of the chaperone policy implemented in a particular setting, the medical record should document the presence or absence of a chaperone for each sensitive examination[1,3,11]. For all examinations or procedures in which a chaperone is present, the medical record should reflect whether the patient requested a chaperone explicitly or whether one was present as a matter of policy. Additionally, the name of the chaperone present and any patient

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preferences regarding the use of a chaperone should also be documented. Note that there is a range of acceptable practices for recording chaperone information and therefore, the extent of documentation, including what precise data to include, varies among medical specialties.

Patients with Diminished or Lacking Decisional Capacity

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

Patient Preferences Regarding Chaperones

With regard to patients' preference for specific characteristics of a chaperone (such as gender or religious affiliation), physicians should be respectful of the patient's values and preferences while also being mindful not to accede to discriminatory or disruptive patient demands. Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship while also creating an "environment that strains relationships among patients, physicians, and the health care team." (Opinion 1.1.2) Discriminatory requests should not typically be accommodated, and accommodation should only occur after careful weighing of the circumstances. Patients' preferences, if nondiscriminatory, should be respected, documented, and upheld within reason and feasibility.

The Use of a Chaperone at Physician Request

There may be times when the physician deems the use of a chaperone necessary. In such cases, if the patient declines, the American College of Obstetricians and Gynecologists (ACOG) suggests that the physician should explain that "the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible"[1]. Ideally, these conversations will be a process of joint decision-making between the patient and the physician. If the patient declines a chaperone when the physician determines having a chaperone present is clinically indicated, every effort should be made to accommodate the preferences of the patient, consistent with the requirements of patient safety, physician safety, and the maintenance of professional boundaries. Physicians should inquire about specific concerns the patient may have and suggest ways these might be addressed in a mutually acceptable manner. Physicians should engage the patient in a detailed discussion of how care might be provided in a way that maintains a comfortable and respectful environment before deciding that they cannot perform the exam or procedure. If the examination is ultimately performed without the use of a chaperone, the rationale should be documented[1]. As a last resort, if the patient and physician cannot come to an agreement, then the physician may defer the examination or procedure and refer the patient to another clinician. In this situation, patients should be provided with "reasonable assistance in making alternative arrangements" so they can receive care in a timely fashion (Opinion 1.1.3).

The Use of a Chaperone without Patient Consent in Exceptional Circumstances

In some situations, insisting on a chaperone when the patient declines may violate the patient's autonomy and therefore be impermissible. However, physicians may proceed with the use of a chaperone without the expressed consent of the patient in the following circumstances:

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

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Pediatric & Adolescent Patients

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

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

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

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

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

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

ETHICS ANALYSIS

There is a power imbalance embedded in the patient-physician relationship. Patients make themselves vulnerable to the physician both by permitting procedures and examinations to be conducted on their bodies and by disclosing private information to the physician during the course of the clinical encounter. The physician guides the care that the patient receives and should adopt practices within the clinical encounter to foster trustworthiness. The presence of a trained chaperone during sensitive examinations contributes to establishing trust between physician and patient, as knowing that the encounter has been witnessed provides everyone involved with reassurance that the encounter was professional and safe.

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

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Chaperones are responsible for upholding the patient's privacy and confidentiality; however, because physicians are obligated to "seek to protect privacy in all settings to the greatest extent possible" (Opinion 3.1.1), opportunities should be provided for private conversation with the patient without the chaperone present. In addition, physicians should minimize inquiries or taking a patient's history during a chaperoned examination or procedure. If a patient shares information with the chaperone that is relevant to patient care but requests that this not be disclosed to the physician, the chaperone should make it clear that they cannot maintain confidentiality when doing so would endanger the health of the patient. The chaperone may also encourage the patient to either raise the issue with the physician themselves or obtain permission from the patient to communicate the information to the physician separately.

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

Since patients may not disclose their history of sexual assault or previous negative healthcare experiences, trauma-informed care (sometimes alternatively described as "healing centered engagement")[5] should be employed for all examinations, including those not usually understood as sensitive. A trauma-informed framework "assumes that all people have experienced trauma, are experiencing it, or may experience it in the future"[6]. This approach is focused on creating "safety, empowerment and trustworthiness" in the clinical encounter[7].

For sexual and gender minority patients, their lived experiences, perspectives and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive[7]. Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient's level of comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for all patients is to be open to broadening the range of circumstances in which a chaperone is used.

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

While opt-in chaperone policies have historically been regarded as adequate, this is no longer the case for some specialties. There is evidence that a shift to opt-out policies will better protect both patients and physicians in many settings. ACOG argues that given "the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone" regular use of chaperones is necessary to assure patients and the public that significant "efforts are being made to create a safe environment for all patients"[1]. Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Similarly, the American College Health Association supports the adoption of opt-out chaperone policies and recommends that every medical institution have a policy regarding sensitive examinations "to protect patients' safety and minimize risk associated with the performance of these exams" that should include the presence of a chaperone for such exams[18].

Physicians deserve to work in an environment where false allegations of misconduct or misunderstandings between physicians and patients do not compromise either their professional reputation or the relationships of trust that they have established with their patients. Likewise, patients deserve to be treated in an environment that supports their agency and improves the quality of their experience, without being expected to make a special request. These goals are best promoted through the implementation of an opt-out policy for the use of chaperones during sensitive exams. Therefore, the presence of chaperones should be standard during sensitive exams and procedures. In other situations, it is recommended that chaperones be made available if the patient requests one. While not mandatory for every clinical encounter, patients should be made aware that they have a right to request a chaperone for any examination. Finally, physicians should honor patients' preferences for a chaperone even when a trusted companion is present.

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CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that the use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Chaperones must be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient. As far as possible, lines of authority in the reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter[3]. Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care. While there are valid concerns related to funding, training, and staffing chaperones, these challenges do not supersede the ethical obligation to provide a chaperone to patients during sensitive examinations and procedures. If physicians feel that they cannot uphold this ethical obligation, they should work with their administrators and specialty associations to remedy the situation.

RECOMMENDATION

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

1. Opinion 1.2.4 "Use of Chaperones" be amended by deletion and addition as follows:

   Chaperones should be authorized members of the health care team. All chaperones should understand the responsibilities of the role and be 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.

   Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clearly explaining various components of the physical examination, and the use of ~~having~~ a chaperone~~ available~~. 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.

   Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship~~ prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, Physicians should:

   (a) Provide a chaperone for all sensitive exams, regardless of patient capacity, unless the delay in obtaining a chaperone would result in significant harm to the patient.

   (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam.

      i. If the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician.

      ii. In emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale.

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~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~

~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~

~~(e)~~(c) Minimize inquiries or history taking ~~of a sensitive nature~~ while a chaperone is present.

(d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries.

(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.

All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk.

For non-sensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request.

2. Policy D-140.950 be rescinded as it has been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: minimal

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2. MANAGING CONFLICT OF INTEREST INHERENT IN NEW PAYMENT MODELS—PATIENT DISCLOSURE

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy

AMA policy D-140.946, "Managing Conflict of Interest Inherent in New Payment Models," adopted at the 2025 Annual Meeting, and asks the following:

> Our AMA will 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.

This report is submitted for the information of the House of Delegates in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician disclosure of financial arrangements.

BACKGROUND

Health care in the United States is currently undergoing a transition in the way systems approach payment and reimbursement for health care services. While, traditionally, health care payment has been based on the volume of services provided (fee-for-service models), alternative models of payment (such as value-based care models) are increasingly being adopted throughout the U.S. due to concerns regarding the lack of equity and focus on patient-centered care that has become endemic with fee-for-service models.[1] Many health care organizations welcome this transition, though proponents of fee-for-services models assert that value-based care also has issues and that we are better off realigning incentives within fee-for service models.[2] Other major shifts in the health care payment landscape include the rise of venture capital and private equity firms' increasing investment in, and acquisition of, physician practices and hospitals;[3] new and emerging technologies, such as personalized medicine and the use of AI tools within medicine, which are adding new complications to financial and reimbursement models;[4,5] and payments to physicians from industry, which remain pervasive despite evidence that such payments may influence clinical decision-making and negatively impact trust in the patient-physician relationship (though payments vary widely both within and between specialties).[6] As financial arrangements between physicians and healthcare facilities, employers, and payors continue to evolve, physicians must strive to ensure that such payment models and financial incentives do not conflict with or prohibit them from upholding their ethical and professional obligations to patients.

ETHICS ISSUES

Physicians have an ethical obligation to prioritize patient welfare over financial incentives; thus, payment models potentially create dual loyalties and conflicts of interest if they encourage physicians to prioritize costs and revenue over patient care. A primary mechanism to protect patients, physicians, and trust in the institution of medicine is through the disclosure of any financial arrangements or other similar factors that could impact patient care. As payment models and financial arrangements become increasingly complex and challenging for patients to understand, there is an ever greater need for physicians to be aware of and understand their ethical obligations related to the appropriate

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disclosure of these financial arrangements, including how to uphold professionalism, informed consent, transparency, and quality care.

ETHICS ANALYSIS & RELEVANT *CODE* OPINIONS

The AMA's *Code of Medical Ethics* is not blind to the potential dangers posed by payment models and financial incentives. Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges that such models "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."[7] The opinion provides specific guidelines for physicians in leadership positions within health care organizations, and for the profession as a whole, on how organizational structures, payment models, and decision-support tools should be implemented to minimize the risk of unethical behavior.

The *Code* includes several other opinions that provide guidance to physicians related to financial arrangements and the importance of disclosing such arrangements. Opinion 11.2.2, "Conflicts of Interest in Patient Care," states that physicians must never "place their own financial interests above the welfare of their patients" and that regardless of the economic interests of any health care entity, if such interests "are in conflict with patient welfare, patient welfare takes priority."[8] This foundational ethical obligation of physicians to prioritize patient care over profits is echoed in Opinion 11.2.3, "Contracts to Deliver Health Care Services."[9] The opinion includes recommendations for physicians to thoroughly review contract terms, avoid conflicts of interest, ensure financial stability, maintain clinical independence, and ensure transparency.

With regards to the importance of maintaining transparency, Opinion 11.2.4, "Transparency in Health Care," states that "physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives, and formularies".[10] The opinion also states that physicians should "[d]isclose any financial and other factors that could affect the patient's care."[10] In essence, this opinion makes it clear that financial disclosure, including disclosure of payment models or other financial incentives that may impact patient care, is a fundamental ethical responsibility for physicians. Additionally, the notion regarding the importance of disclosure is supported by Opinion 2.1.1, "Informed Consent," which highlights the value of transparent communication in fostering trust and shared decision-making. Taken together, these opinions require that physicians inform patients of all medically appropriate treatment options and that they disclose existing financial incentives or payment models that impact care decisions.[11]

CONCLUSION

The increasing corporatization of medicine, and the associated consolidation of health care entities, has been met by the emergence of new payment models in response to these changes. Despite shifts in payment models, it is crucial to recognize that any payment model has the potential to create conflicts of interest. Important steps to minimize such risks include prioritizing patient care above financial interests, supporting transparency through financial disclosure, and practicing informed consent and shared decision-making, as outlined in the *Code of Medical Ethics*.

RECOMMENDATION

The Council on Ethical and Judicial affairs recommends that Policy D-140.946 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: REFERRED

Council on Ethical and Judicial Affairs (CEJA) Report 8, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was introduced by CEJA at the 2025 Annual Meeting and was referred. CEJA Report 08-A-25 responded to Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," which was adopted at the 2023 Annual Meeting and asks the following:

1. Our American Medical Association will reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally.

2. Our AMA will request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

The House testified against the word "could" in recommendation (c) of CEJA Report 8-A-25, noting that its use is too broad, nonspecific, and might restrict physicians' ability to take collective action. CEJA appreciates that the use of "could" created an insurmountable bar, and so as a result, in recognition of physicians' fiduciary duties and the need for physician advocacy, CEJA has reached a balance by changing "could" to "would likely" in recommendation (c) for greater clarity. At the 2025 Interim Meeting, the House again referred the report and voiced comments directing CEJA to edit specific language, this time requesting that the use of "could" in recommendation (e) be amended to mirror the new language of "would likely" in recommendation (c).
While in the I-25 report, recommendation (c) pertains to all forms of collective actions, recommendation (e) is specific to disruptive collective actions that could directly compromise patient care. This report defines a disruptive collective

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action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Disruptive collective actions are thus more likely than non-disruptive actions to cause harm to patients and therefore necessitate a higher ethical burden to be justified, as outlined in recommendations (d) and (e). The Council has discussed the different language used in the I-25 report recommendations and believes that the use of "could directly" in recommendation (e) best describes the reality of disruptive collective actions and correctly reflects physicians' ethical obligations. However, to help clarify this hierarchy of ethical burden, recommendations (c), (d), and (e) of the I-25 report have been reorganized as subsections i, ii, and iii, respectively, under recommendation (b) in this report. Recommendation (e), now iii, has also been revised to better reflect physicians' primary ethical obligation to patient welfare (ahead of other considerations including their own self-interest or obligations to others) and the potential for disruptive collective actions that could directly compromise patient care to interfere with this duty. The Council also wishes to highlight that the use of "should" is not a prohibition and does not mean physicians must never engage in such actions. The recommendations presented in this report do not prohibit physicians from striking but rather lay out the ethical obligations under which such disruptive collective actions could take place.

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities.[1] Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019.[2] As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1 percent of practicing physicians.[1] Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

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

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

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

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Relevant Laws

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

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

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

Relevant AMA Policy Provisions

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

Relevant Code *Provisions*

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

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

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

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

Additional Relevant Policy

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

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.
3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care.[13]

ETHICAL ISSUE

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

REVIEW OF RELEVANT LITERATURE

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

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

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they

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cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognizes physicians as laborers with all the rights of laborers, while drawing limits that protect the public from harm.

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

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large health care systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if impediments to good patient care are sufficiently serious, and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short-run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified.[6,19] These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed, and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived, or, at least, difficult for the public to believe.[6,19,21]

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

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

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

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

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

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care,[25-28] much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.[26,27] Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes.[25] Importantly, a 2019 study found a

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slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain[28]. This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution.[29]

ETHICAL ANALYSIS

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

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

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

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

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

CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted.

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Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

b. Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes

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by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

c. Physicians should avoid disruptive collective actions that could directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest.

(c) 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.

(d) 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.

Fiscal Note: Minimal

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4. CARCERAL SYSTEMS AND PRACTICES IN BEHAVIORAL HEALTH EMERGENCY CARE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-345.970(3), "Carceral Systems and Practices in Behavioral Health," was adopted at the 2025 AMA Annual Meeting, and directs the following:

> 3. Our AMA asks the Council on Ethical and Judicial Affairs to study this topic to provide clearer guidance for healthcare professionals regarding interactions with law enforcement while caring for patients and shackling of youth and adults in carceral custody, with particular attention to the removal of.

The medical care of persons in legal custody presents a range of complex ethical considerations for physicians and other health professionals. When caring for individuals in legal custody, physicians may face competing obligations arising from institutional circumstances such as security requirements or law enforcement involvement.

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In response to the directive in D-345.970(3), the Council on Ethical and Judicial Affairs (CEJA) is studying these issues to determine whether additional guidance in the AMA *Code of Medical Ethics* is warranted. A forthcoming Council report will examine the ethical considerations associated with the treatment of persons in legal custody.

5. CEJA'S SUNSET REVIEW OF 2016 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

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

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

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

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

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

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

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

RECOMMENDATION

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

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APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-370.985	Organ Donation	Our AMA will study potential models for increasing the United States organ donor pool.	Retain; remains relevant.
G-600.130	Meeting Calendar and Locations	AMA policy on the meeting calendar for the House includes the following: (1) Our AMA should make reasonable efforts to avoid scheduling future Annual Meetings that conflict with Father's Day weekend; (2) The Interim Meeting of the House of Delegates will be held in the second or third week in November; and (3) Our AMA supports scheduling more meetings in Washington, DC, specifically including Interim Meetings of the House on a rotating schedule as frequently as practicable. Our AMA believes, however, that it would not be financially prudent to hold all Interim Meetings in Washington, DC, nor would such a decision be equitable for other regions of the country.	Retain; remains relevant.
H-140.840	Filming Patients for News or Entertainment	American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique)?do not substitute for the need to obtain consent, as outlined in AMA Ethical Opinion E-5.045, for publication of any material related to the treatment of a patient.	Retain as amended: American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique)~~?~~do not substitute for the need to obtain consent, as outlined in ~~AMA Ethical Opinion E-5.045~~ the AMA Code of Medical Ethics Opinions 3.1.3 and 3.1.4, for publication of any material related to the treatment of a patient
H-140.966	Decisions Near the End of Life	Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.	Retains; remains relevant.

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Policy Number	Title	Text	Recommendation
		(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management.	
H-160.999	Statements on the Medical Profession	Whether definitely stated or not, it is the position of the AMA that all conditions or principles adopted by the Association concerning the position of the medical profession, in any form of medical practice, are set forth primarily in order to maintain such standards as are essential to the maintenance of the best medical care and the protection of the health of all members of the community.	Retain; remains relevant.
H-175.993	Fraudulent Health Practices	The AMA favors providing information and educational materials to the public and the profession on fraudulent health practices.	Retain; remains relevant.
H-230.966	Physician Appeals Mechanism for Denial of Academic Appointment	Hospital governing boards and hospital medical staffs through their Bylaws must remain responsible for medical staff selection. In situations in which hospital medical staff privileges are granted by contract on the condition of an academic appointment, the physician must be made aware of and agree to the linkage. Under those circumstances when a physician may lose an academic appointment after full and fair due process, no further action is required for revocation of hospital medical staff privileges.	Retain; remains relevant.

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Policy Number	Title	Text	Recommendation
H-270.960	Inappropriate Legislative Mandates of eGFR Calculations	Our AMA supports the position that (1) the estimated Glomerular Filtration Rate Calculation (eGFR) calculation, when appropriate and feasible, is a clinically useful calculation that should be promoted in the medical community in a scientific manner as a calculation that does NOT require state legislation or state law that would create an inflexible, politically-based mandate for the practice of medicine that, in general, can be deleterious to patient care; and (2) legislation mandating the eGFR calculation improperly and detrimentally prescribes medical decision-making to the extent that it deprives a physician of the ability to make appropriate, patient-specific clinical judgments regarding the performance of the calculation.	Retain; remains relevant.
H-275.990	Clinical Diagnostic Electromyography	1. Clinical diagnostic electromyographic examinations--involving the selection of the muscles to be studied, modifying the examination as the data unfold, inserting the needle electrodes, recording of and interpreting the data thereby obtained, describing the findings, and the rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data and the electromyographic findings--is the practice of medicine and should be performed only by a fully licensed physician qualified by reason of education, training, and experience in these procedures. 2 Non-physician health care professionals should not expand their scope of practice to include performing needle electromyography. 3. Physicians should not prepare reports and submit claims on needle electromyographic studies that they did not perform or personally supervise. 4. State boards of medical examiners should investigate and take appropriate action whenever cases involving the performance of clinical electromyographic examinations by unqualified persons contrary to the state medical practice acts are brought to their attention.	Retain; remains relevant.
H-370.964	Surrogate Consent for Living Organ Donation	Our AMA opposes the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.	Retain; remains relevant.
H-450.928	Physician Decision Making	Our AMA advocates that treating and attending physicians, regardless of employment status, must maintain overall leadership in decisions affecting the health care received by patients in order to ensure quality of the care given to patients.	Retain; remains relevant.
H-450.990	Physician Information for Credentialing	Our AMA: (1) affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body; and (2)	Retain; remains relevant.

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Policy Number	Title	Text	Recommendation
		believes that legal immunity for submitting or sharing truthful and accurate information on quality care should be provided to physicians by appropriate legislation.	

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

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

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APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2025 – MARCH 31, 2026

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

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
11	No sanction or other type of action
3	Monitoring
8	Probation
2	Revocation
0	Suspension
1	Denied
0	Suspension lifted
12	Censure

Physicians Reviewed	PROBATION/MONITORING STATUS
11	Members placed on Probation/Monitoring during reporting interval
8	Members placed on Probation without reporting to Data Bank
12	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
30	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
9	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

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