

## Reference Committee on Ethics and Bylaws

### **Report(s) of the Board of Trustees**

- 02 New Specialty Organizations Representation in the House of Delegates

### **Report of the Council on Constitution and Bylaws**

- 02 HOD Representation and Composition
- 03 Rights & Privileges of HOD Members
- 04 Credentialing of HOD Delegates and Alternate Delegates
- 05 Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
- 06 Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
- 07 HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
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- 09 Continuity of AMA Resident and Fellow Section Governing Council Leadership

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- 01 Guidelines on Chaperones for Sensitive Exams
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- 002 Physician Workload and Scheduling
- 003 Artificial Intelligence to Bolster Physician-Led Team-Based Care
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- 005 Impersonation of a Physician
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- 007 Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software
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- 009 Preserving Access to Care for Undocumented Individuals
- 010 Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

REPORT OF THE BOARD OF TRUSTEES

BOT Report 02-A-26

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the  
2 applications of the American Association of Hip and Knee Surgeons, the American Epilepsy  
3 Society, and the American Society of Neuroimaging for national medical specialty organization  
4 representation in the American Medical Association (AMA) House of Delegates (HOD). The  
5 applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS  
6 Assembly for consideration.

7  
8 The applications were considered using criteria developed by the Council on Long Range Planning  
9 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

10  
11 Organizations seeking admission were asked to provide appropriate membership information to the  
12 AMA. That information was analyzed to determine AMA membership, as required under criterion  
13 three. A summary of this information is attached to this report as Exhibit B.

14  
15 In addition, organizations must submit a letter of application in a designated format. This format  
16 lists the above-mentioned guidelines followed by each organization's explanation of how it meets  
17 each of the criteria.

18  
19 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.  
20 These organizations have actively participated in the SSS for more than three years.

21  
22 Review of the materials and discussion during the SSS meeting at the November 2025 Interim  
23 Meeting indicated that the American Association of Hip and Knee Surgeons, the American  
24 Epilepsy Society, and the American Society of Neuroimaging meet the criteria for representation in  
25 the HOD.

26  
27 **RECOMMENDATION**

28  
29 Therefore, the Board of Trustees recommends that the American Association of Hip and Knee  
30 Surgeons, the American Epilepsy Society, and the American Society of Neuroimaging be granted  
31 representation in the AMA House of Delegates and that the remainder of the report be filed.  
32 (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX  
Exhibit A

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

**National Medical Specialty Societies**

- 1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
- 2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
- 3) The organization must meet one of the following criteria:
  - 1,000 or more AMA members;
  - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
  - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
- 4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.
- 5) Physicians should comprise the majority of the voting membership of the organization.
- 6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.
- 7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.
- 8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
- 9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
- 10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

**RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS**

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

***Exhibit B - Summary Membership Information***

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Association of Hip and Knee Surgeons	784 of 3,672 (21%)
American Epilepsy Society	389 of 1,961 (20%)
American Society of Neuroimaging	101 of 230 (43%)

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-26

Subject: HOD Representation and Composition

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

Referred to: Reference Committee on Ethics and Bylaws

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1 The AMA House of Delegates (HOD) is the policy-making body of our American Medical  
2 Association (AMA). It is democratically structured and comprised of delegates from constituent  
3 associations (state medical societies), national medical specialty societies, professional interest  
4 medical associations, the Federal services, the AMA Sections, medical student regional  
5 representatives, resident and fellow sectional representatives and other groups with HOD  
6 representation. A complete list of those represented societies is [online](#), as is the [2026](#)  
7 [apportionment of delegates](#) for each. Additionally, groups represented in the HOD are invited to  
8 identify one alternate delegate for each delegate apportioned to the group.

9  
10 There is parity of representation between the constituent associations and the national medical  
11 specialty societies. Each constituent association is apportioned one delegate and one alternate  
12 delegate for each 1,000 (or fraction thereof) active members of the AMA, including medical  
13 students and residents and fellows. The national medical specialty societies then receive that same  
14 number of delegates and alternate delegates and those positions are apportioned back to the  
15 individual specialty societies according to AMA [Policy G-600.027](#). Each AMA Section and  
16 professional interest medical association granted representation in the HOD receives one delegate  
17 and one alternate delegate regardless the size of its membership. There are also two groups in our  
18 House of Delegates – medical student regional delegates and resident and fellow sectional  
19 delegates, whose apportionment is codified in the AMA Bylaws (Bylaw [2.3.2](#) and [2.4.2](#)) and which  
20 is based on medical student and resident and fellow AMA membership.

21  
22 While the HOD treats all delegations equally, they are constituted differently. In general, the  
23 Bylaws do not prescribe the process by which most organizations represented in the House of  
24 Delegates choose their delegates and alternate delegates. These groups have organizational  
25 autonomy and can fill their delegation positions however they choose so long as the individuals are  
26 AMA active members and members of the organization, and have autonomy when it comes to how  
27 they fill unfilled positions or vacancies. Medical students and resident and fellow physicians are  
28 eligible for service on an organization's delegation as either a delegate or an alternate delegate so  
29 long as they are AMA members and members of the organization. CCB Reports 5 and 7 provide  
30 additional details.

31  
32 The Council has prepared this report to propose Bylaw amendments that further emphasize the  
33 inclusive nature of the HOD, with further nuances addressed in other A-2026 CCB reports.

1 RECOMMENDATIONS

2  
3 The Council on Constitution and Bylaws recommends that the following Bylaws amendments  
4 (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder of the  
5 report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of  
6 Delegates present and voting following a one-day layover.

7  
8 **2—House of Delegates**

9  
10 **2.0.1 Composition and Representation. \*\*\***

11  
12 **2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of  
13 Delegates must be active members of the AMA, including resident and fellow  
14 physicians and medical students, and of the entity they represent.

15  
16 **2.0.1.2 Representation.** The representational role of the delegates is multi-dimensional  
17 and includes:

- 18  
19 a. Advocacy for patients to improve the health of the public and the health care  
20 system.  
21  
22 b. Representation of the perspectives of the delegate’s sponsoring organization to  
23 the House of Delegates.  
24  
25 c. Representation of the delegate’s physician and medical student constituents in  
26 the decision-making process of the House of Delegates.  
27  
28 d. Representation of the AMA and the House of Delegates to physicians, medical  
29 associations, and others, including resident and fellow physicians and medical  
30 students.  
31  
32 e. Solicitation of input from and provision of feedback to constituents.

33  
34 **2.0.1.2.1 Consideration.** In considering business, delegates should take into  
35 consideration the perspectives of their patients, their sponsoring  
36 organizations, and their medical student or physician constituents. In  
37 voting on matters before the House of Delegates, delegates should vote  
38 on the basis of what is best for patients and quality medical care.

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41  
42 **2.0.1.3 ~~2.8~~ Alternate Delegates.** Each organization represented in the House of  
43 Delegates ~~may select~~ is allotted an alternate delegate for each of its delegates  
44 entitled to be seated in the House of Delegates. Alternate delegates must meet the  
45 criteria specified in Bylaw 2.0.1.1 and be similarly credentialed per the Bylaws  
46 that govern credentialing for the delegates representing their organization. Terms  
47 for alternate delegates shall be the same as for the delegates.

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**2.10.7**

**2.0.1.4** **Unique Representation.** No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

**2.0.1.5** **Registration.** All attendees of a House of Delegates meeting must register for the meeting.

**2.0.1.3**

**2.0.1.6** **Autonomy.** The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

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

**2.1.1** **Apportionment.** The apportionment of delegates from each constituent association is one delegate and one alternate delegate for each 1,000 (or fraction thereof), active members of the AMA including medical students and residents and fellows within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

**2.1.1.1** **Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. **~~2.10.1. Notification~~** In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

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**2.1.4** **Term.** Delegates and alternate delegates from constituent associations shall be selected for two 2-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

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**2.2** **National Medical Specialty Societies Delegations.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the

1 total number of delegates apportioned to constituent societies under sections 2.1.1 using  
2 methods specified in AMA policy.

3  
4 **2.2.1 Apportionment.** The apportionment of delegates from each specialty society  
5 represented in the AMA House of Delegates is one delegate and alternate delegate  
6 for each 1,000, or fraction thereof, physician specialty society members, including  
7 residents and fellows, as of December 31 of each year who are eligible to serve on  
8 committees or the governing body, are active members of the AMA and are  
9 members in good standing and current in payment of applicable dues of both the  
10 specialty society and the AMA.

11  
12 **2.2.1.1 Effective Date.** Such apportionment shall take effect on January 1 of the  
13 following year and shall remain effective for one year. ~~2.10.1.~~  
14 **Notification.** In January of each year, the AMA shall notify each  
15 organization of the number of seats in the House of Delegates to which it  
16 is entitled during the current year.

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19  
20 **2.2.4 Term.** Delegates and alternate delegates from specialty societies shall be selected  
21 for two 2-year terms, and shall assume office on the date set by the specialty  
22 society provided that such seats are authorized pursuant to these Bylaws. Specialty  
23 societies entitled to more than one delegate and alternate delegate shall select them  
24 so that half the number, as near as may be, are selected each year. One-year terms  
25 may be provided but only to the extent and for such time as is necessary to  
26 accomplish this proportion.

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29 **2.6 Other Delegates and Alternate Delegates.** Each of the following is entitled to a delegate  
30 and an alternate delegate: AMA Sections; the Surgeons General of the United States Army,  
31 United States Navy, United States Air Force, and United States Public Health Service; the  
32 Chief Medical Director of the Department of Veterans Affairs; the National Medical  
33 Association; the American Medical Women's Association; the American Osteopathic  
34 Association; and professional interest medical associations granted representation in the  
35 House of Delegates.

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38  
39 **2.6.2 Term.** Delegates and alternate delegates from these entities shall be selected for  
40 two 2-year terms, and shall assume office on the date set by the entity. \*\*\*

41  
42 (Modify Bylaws)

## CLEAN BYLAW LANGUAGE IF ADOPTED

### 2—House of Delegates

#### 2.0.1 Composition and Representation. \*\*\*

**2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of Delegates must be active members of the AMA, including resident and fellow physicians and medical students, and of the entity they represent.

**2.0.1.2 Representation.** The representational role of the delegates is multi-dimensional and includes:

- a. Advocacy for patients to improve the health of the public and the health care system.
- b. Representation of the perspectives of the delegate's sponsoring organization to the House of Delegates.
- c. Representation of the delegate's physician and medical student constituents in the decision-making process of the House of Delegates.
- d. Representation of the AMA and the House of Delegates to physicians, medical associations, and others, including resident and fellow physicians and medical students.
- e. Solicitation of input from and provision of feedback to constituents.

**2.0.1.2.1 Consideration.** In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their medical student or physician constituents. In voting on matters before the House of Delegates, delegates should vote on the basis of what is best for patients and quality medical care.

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**2.0.1.3 Alternate Delegates.** Each organization represented in the House of Delegates is allotted an alternate delegate for each of its delegates entitled to be seated in the House of Delegates. Alternate delegates must meet the criteria specified in Bylaw 2.0.1.1 and be similarly credentialed per the Bylaws that govern credentialing for the delegates representing their organization. Terms for alternate delegates shall be the same as for the delegates.

**2.0.1.4 Unique Representation.** No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

**2.0.1.5 Registration.** All attendees of a House of Delegates meeting must register for the meeting.

**2.0.1.6 Autonomy.** The participation of any organization in the House of Delegates is voluntary. Policy actions of the AMA do not in themselves bind an organization or subject it to any obligation that it does not voluntarily assume.

**2.1 Constituent Association Delegations.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

**2.1.1 Apportionment.** The apportionment of delegates from each constituent association is one delegate and one alternate delegate for each 1,000 (or fraction thereof), active members of the AMA including medical students and residents and fellows within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

**2.1.1.1 Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

\*\*\*

**2.1.4 Term.** Delegates and alternate delegates from constituent associations shall be selected for two-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate and one alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

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**2.2 National Medical Specialty Society-Delegations.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment. The total number of apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 using methods specified in AMA policy.

**2.2.1 Apportionment.** The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate and alternate delegate for each 1,000, or fraction thereof, physician specialty society members, including residents and fellows, as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA.

**2.2.1.1 Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

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**2.2.4 Term.** Delegates and alternate delegates from specialty societies shall be selected for two-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate and alternate delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

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**2.6 Other Delegates and Alternate Delegates.** Each of the following is entitled to a delegate and an alternate delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

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**2.6.2 Term.** Delegates and alternate delegates from these entities shall be selected for two-year terms, and shall assume office on the date set by the entity.

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-A-26

Subject: Rights & Privileges of HOD Members

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

Referred to: Reference Committee on Ethics and Bylaws

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1 At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report  
2 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council  
3 opted to separate the issues it addressed into several focused reports.

4  
5 This report presents new language to specifically address the rights of those delegates and alternate  
6 delegates who are affiliated with the House of Delegates as well as relevant HOD procedures.  
7 Current Bylaws address the rights and privileges of Ex Officio Members (of the House) [[Bylaw](#)  
8 [2.7](#)], Rights of Official Observers (to the House) [[Bylaw 2.9.1](#)], the Rights of the Speakers [[Bylaw](#)  
9 [2.5](#), [4.4](#) and [4.5](#)], Rights of Temporary Substitute Delegates [[Bylaw 2.10.4.1](#)] and the rights of  
10 Alternate Delegates [[Bylaw 2.8](#)], but provides no language explicitly addressing the rights and  
11 privileges of delegates. This report provides that language as well as additional amended language  
12 to address the rights and privileges of alternate delegates. It also relocates existing provisions  
13 acknowledging that a constituent association president or national medical specialty society or  
14 professional interest medical association president may be credentialed as an additional alternate  
15 delegate for the societies they represent. In doing so and in eliminating redundant text, some  
16 renumbering has occurred.

## 17 18 RECOMMENDATIONS

19  
20 The Council on Constitution and Bylaws recommends that the following Bylaws amendments and  
21 deletions (shown in red and amended by [insertion](#) or [deletion](#)) be adopted, and that the remainder  
22 of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
23 House of Delegates present and voting following a one-day layover.

### 24 25 **2—House of Delegates**

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29 **2.0.1 Composition and Representation.** The House of Delegates is composed of delegates  
30 selected by recognized constituent associations and specialty societies, and other delegates  
31 as provided in this bylaw. [A delegate may introduce resolutions into the House of](#)  
32 [Delegates, speak and debate on the floor of the House, offer an amendment to a pending](#)  
33 [matter, make motions, vote on items of business and vote in elections.](#)

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36  
37 **2.0.1.1 Qualification of Members of the House of Delegates.** \*\*\*

1           **2.0.1.2 Representation.** \*\*\*

2  
3           **2.0.1.3 ~~2.8~~ Alternate Delegates.** \*\*\*

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5           **2.0.1.3.1—~~2.8.5~~ Rights and Privileges. ~~An alternate delegate may substitute for a~~  
6           ~~delegate, on the floor of the House of Delegates, at the request of the~~  
7           ~~delegate by complying with the procedures established by the~~  
8           ~~Committee on Rules and Credentials.~~ ~~**2.8.6 Status.**~~ The alternate  
9           delegate is not a “member of the House of Delegates” as that term is  
10          used in these Bylaws. Accordingly, an alternate delegate may not  
11          introduce resolutions into the House of Delegates, nor vote in any  
12          election conducted by the House of Delegates. An alternate delegate is  
13          not eligible for nomination or election as Speaker or Vice Speaker of  
14          the House of Delegates.**

15  
16          **2.0.1.3.2 Alternate Delegate Seated for a Delegate.** ~~**2.8.5** At the request of~~  
17          ~~their corresponding delegate, An alternate delegate may be seated for~~  
18          ~~them substitute for a delegate, on the floor of the House of Delegates;~~  
19          ~~at the request of the delegate by complying with the procedures~~  
20          ~~established by the Committee on Rules and Credentials. The alternate~~  
21          ~~delegate must display their corresponding delegate’s temporary~~  
22          ~~credential (salmon badge). While seated substituting for a delegate, the~~  
23          alternate delegate may speak and debate on the floor of the House,  
24          offer an amendment to a pending matter, make motions, and vote.  
25          ~~**2.8.6** The alternate delegate must immediately relinquish their position~~  
26          ~~on the floor of the House of Delegates at upon the request of the~~  
27          ~~delegate for whom the alternate delegate is substituting their~~  
28          ~~corresponding delegate.~~

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30          ~~**2.8.1—Qualifications.** Alternate delegates must be active members of~~  
31          ~~the AMA and of the entity they represent.~~

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33          ~~**2.8.2—Certification.** Alternate delegates shall be certified to the~~  
34          ~~AMA in the same manner as delegates.~~

35  
36          ~~**2.8.3—Term.** Alternate delegates shall be selected for a 2-year term,~~  
37          ~~and shall assume office on the date set by the organization,~~  
38          ~~unless otherwise provided in these Bylaws.~~

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40          ~~**2.8.4—Vacancies.** Alternate delegates selected to fill a vacancy shall~~  
41          ~~assume office immediately after selection and shall serve for~~  
42          ~~the remainder of that term.~~

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46          **2.5 Speaker and Vice Speaker Additional Delegates.** Upon election of the Speaker and Vice  
47          Speaker of the House of Delegates from among the members of the House of Delegates,  
48          the organizations represented by the delegates elected to be Speaker and Vice Speaker of  
49          the House of Delegates shall be entitled to an additional delegate for the term of service of  
50          the Speaker and Vice Speaker. The additional delegates so selected shall have the full  
51          rights and privileges of delegates in the House of Delegates.

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**2.5.1 ~~Rights and Privileges Status of Speaker and Vice Speaker~~.** Upon their election, the Speaker and Vice Speaker shall continue to be members of the House of Delegates, with all of the rights and privileges of members of the House of Delegates. They shall be entitled to vote in the House of Delegates. The Speaker and Vice Speaker, as members of the House of Delegates, shall be eligible to be nominated for re-election to the office of Speaker and Vice Speaker of the House of Delegates.

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**2.8 Additional Alternate Delegates.**

**2.8.1**  
**~~2.10.5~~ Constituent Association President.** The current president of a constituent association may also be ~~certified~~ credentialed as an additional alternate delegate at the discretion of each constituent association.

**2.8.2**  
**~~2.10.6~~ National Medical Specialty Society or Professional Interest Medical Association President.** The current president of a national medical specialty society or a professional interest medical association may also be ~~certified~~ credentialed as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

(Modify Bylaws)

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**2.0.1 Composition and Representation.** The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

\*\*\*

**2.0.1.1 Qualification of Members of the House of Delegates.** \*\*\*

/

**2.0.1.2 Representation.** \*\*\*

**2.0.1.3 Alternate Delegates.** \*\*\*

**2.0.1.3.1—Rights and Privileges.** The alternate delegate is not a “member of the House of Delegates” as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

**2.0.1.3.2 Alternate Delegate Seated for a Delegate.** At the request of their corresponding delegate, an alternate delegate may be seated for them on the floor of the House of Delegates. The alternate delegate must display their corresponding delegate’s temporary credential (salmon badge). While seated for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates at the request of their corresponding delegate.

\*\*\*

**2.5 Speaker and Vice Speaker Additional Delegates.** Upon election of the Speaker and Vice Speaker of the House of Delegates from among the members of the House of Delegates, the organizations represented by the delegates elected to be Speaker and Vice Speaker of the House of Delegates shall be entitled to an additional delegate for the term of service of the Speaker and Vice Speaker. The additional delegates so selected shall have the full rights and privileges of delegates in the House of Delegates.

**2.5.1 Rights and Privileges.** Upon their election, the Speaker and Vice Speaker shall continue to be members of the House of Delegates, with all of the rights and privileges of members of the House of Delegates. They shall be entitled to vote in the House of Delegates. The Speaker and Vice Speaker, as members of the House of Delegates, shall be eligible to be nominated for re-election to the office of Speaker and Vice Speaker of the House of Delegates.

\*\*\*

**2.8 Additional Alternate Delegates.**

**2.8.1 Constituent Association President.** The current president of a constituent association may also be credentialed as an additional alternate delegate at the discretion of each constituent association.

**2.8.2 National Medical Specialty Society or Professional Interest Medical Association President.** The current president of a national medical specialty society or a professional interest medical association may also be credentialed as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 4-A-26

Subject: Credentialing of HOD Delegates and Alternate Delegates

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

Referred to: Reference Committee on Ethics and Bylaws

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1 At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report  
2 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council  
3 opted to separate the issues it addressed into several focused reports.  
4

5 This report presents amended language to more accurately address the appropriate credentialing  
6 authority for all groups with representation in the HOD, including the credentialing authorities for  
7 the AMA Section delegates and alternate delegates, the regional medical student delegates and  
8 alternate delegates and the resident and fellow sectional delegates and alternate delegates.  
9

10 As noted in referred CCB Report 3-I-25, the Council looked at the disparate provisions that govern  
11 the credentialing of delegates and alternate delegates and noted several outmoded provisions and  
12 inaccuracies. The term “certification” referred to an obsolete process whereby each group  
13 represented in the HOD manually completed a form listing their delegates and alternate delegates  
14 and then certified the accuracy of that information. While the Council understands that the term  
15 certification may have varying implications or significance for different purposes and delegations,  
16 the term “credentialing” more appropriately reflects the current process.  
17

## 18 RECOMMENDATIONS

19

20 The Council on Constitution and Bylaws recommends that the following Bylaws amendments and  
21 deletions (shown in red and amended by insertion or deletion) be adopted, and that the remainder  
22 of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
23 House of Delegates present and voting following a one-day layover.  
24

25 **2.1.3 ~~Certification-Credentialing.~~** The president or chief executive officer of each constituent  
26 association, or ~~the president's their~~ designee, shall provide certify to the AMA Office of  
27 House of Delegates Affairs with the names and contact information of their delegates and  
28 alternate delegates ~~from their respective associations. Certification must occur~~ at least 45  
29 days prior to each meeting the Annual or Interim Meeting of the House of Delegates.  
30 These appropriately identified individuals shall be duly credentialed for that meeting only.  
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34 **2.2.3 ~~Certification Credentialing.~~** The president or chief executive officer of each specialty  
35 society, or ~~the president's their~~ designee, shall provide certify to the AMA Office of House  
36 of Delegates Affairs with the names and contact information of their delegates and  
37 alternate delegates ~~from their respective societies. Certification must occur~~ at least 45 days

1 prior to each meeting the Annual or Interim Meeting of the House of Delegates. These  
2 appropriately identified individuals shall be duly credentialed for that meeting only.  
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6 **2.3.4** **Certification Credentialing.** The ~~C~~chair of the Medical Student Section Governing  
7 Council or the director of the Medical Student Section, or their ~~Chair's~~ designee, shall  
8 provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and  
9 contact information of the delegates and alternate delegates for each Medical Student  
10 Region elected in accordance with 2.3.3. ~~Certification Credentialing~~ must occur at least 45  
11 days prior to each meeting the Annual Meeting of the House of Delegates. These  
12 appropriately identified individuals shall be duly credentialed for that meeting only.  
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16 **2.4.4** **Certification Credentialing.** The ~~C~~chair of the Resident and Fellow Section Governing  
17 Council or the director of the Resident and Fellow Section, or their ~~Chair's~~ designee, shall  
18 provide ~~certify to~~ the AMA Office of House of Delegates Affairs the names and contact  
19 information of the resident and fellow sectional delegates and alternate delegates elected in  
20 accordance with 2.4.3. ~~Certification Credentialing~~ of delegates and alternate delegates must  
21 occur at least 45 days prior to each meeting the Annual Meeting of the House of Delegates.  
22 These appropriately identified individuals shall be duly credentialed for that meeting only.  
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26 **2.6.1** **Certification Credentialing.** The president, chief executive officer, AMA Section chair or  
27 director, or other authorized individual of each entity described in Bylaw 2.6 shall provide  
28 ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact  
29 information of their respective delegate and alternate delegate at least 45 days prior to each  
30 meeting the Annual or Interim Meeting of the House of Delegates. These appropriately  
31 identified individuals shall be duly credentialed for that meeting only.  
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33 **2.6.2** **Term.** ~~\*\*\*Certification of delegates and alternate delegates must occur at least 45 days~~  
34 ~~prior to the Annual or Interim Meeting of the House of Delegates.~~  
35

36  
37 (Modify Bylaw)

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**2.1.3 Credentialing.** The president or chief executive officer of each constituent association, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates-at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

\*\*\*

**2.2.3 Credentialing.** The president or chief executive officer of each specialty society, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

\*\*\*

**2.3.4 Credentialing.** The chair of the Medical Student Section Governing Council or the director of the Medical Student Section, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3. Credentialing must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

\*\*\*

**2.4.4 Credentialing.** The chair of the Resident and Fellow Section Governing Council or the director of the Resident and Fellow Section, or their designee, shall provide the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3. Credentialing of delegates and alternate delegates must occur at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

\*\*\*

**2.6.1 Credentialing.** The president, chief executive officer, AMA Section chair or director, or other authorized individual of each entity described in Bylaw 2.6 shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 5-A-26

Subject: Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations

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

Referred to: Reference Committee on Ethics and Bylaws

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1 At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report  
2 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council  
3 opted to separate the issues it addressed into several focused reports.  
4

5 Previously the Council had recommended deletion of Bylaw 2.1.6 that acknowledged the ability of  
6 a constituent association to include a medical or resident and fellow physician on its delegation.  
7 The Council had recommended deletion as constituent associations are autonomous and thus may  
8 select a delegate by a mechanism of its choice. However, there was significant testimony opposing  
9 deletion of that language with additional testimony supporting equivalent language for the national  
10 medical specialty societies.  
11

12 This report presents updated language to reflect the HOD's will. The report also recognizes the  
13 ability of a professional interest medical association and other groups to similarly fill its delegate or  
14 alternate delegate positions with a resident/fellow physician member and/or a medical student  
15 member. Lastly, the Council acknowledges its awareness that its amended language refers to  
16 "resident/fellow physician" rather than "resident and fellow physician" as is used in other Bylaw  
17 provisions but believes the usage of "resident/fellow" is appropriate here.  
18

## 19 RECOMMENDATIONS

20  
21 The Council on Constitution and Bylaws recommends that the following Bylaws amendments and  
22 deletions (shown in red and amended by insertion or ~~deletion~~) be adopted, and that the remainder  
23 of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
24 House of Delegates present and voting following a one-day layover.  
25

26 **2.1.2 Selection.** Each constituent association shall select and adjust the number of  
27 delegates and alternate delegates to conform with the number of seats authorized  
28 under this bylaw.  
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32 **2.1.6 Resident/Fellow Physician and Medical Student Delegates and Alternate**  
33 **Delegates.** A constituent association may designate one or more of its delegate and  
34 alternate delegate seats to be filled by a resident/fellow physician member or a  
35 medical student member.

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**2.1.6.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term ~~beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA.~~

**2.1.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full ~~two~~-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.

\*\*\*

**2.2.2 Selection.** Each specialty society shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

\*\*\*

**2.2.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates.** A national medical specialty society may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

**2.2.6.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

**2.2.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.4.

\*\*\*

**2.6 Other Delegates. \*\*\***

\*\*\*

**2.6.2 Term. \*\*\***

**2.6.2.1 Resident/Fellow Physician and Medical Student Delegates.** These entities may designate their delegate and/or alternate delegate seat to be filled by a resident/fellow physician member or a medical student member.

**2.6.2.1.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

**2.6.2.1.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

(Modify Bylaws)

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**2.1.2 Selection.** Each constituent association shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

\*\*\*

**2.1.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates.** A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

**2.1.6.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

**2.1.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.

\*\*\*

**2.2.2 Selection.** Each specialty society shall select and adjust the number of delegates and alternate delegates to conform with the number of seats authorized under this bylaw.

\*\*\*

**2.2.6 Resident/Fellow Physician and Medical Student Delegates and Alternate Delegates.** A national medical specialty society may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

**2.2.6.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

**2.2.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.4.

\*\*\*

**2.6 Other Delegates.** \*\*\*

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**2.6.2 Term.** \*\*\*

**2.6.2.1 Resident/Fellow Physician and Medical Student Delegates.** These entities may designate their delegate and/or alternate delegate seat to be

filled by a resident/fellow physician member or a medical student member.

**2.6.2.1.1 Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term.

**2.6.2.1.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full two-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.6.2.

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 6-A-26

Subject: Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD

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

Referred to: Reference Committee on Ethics and Bylaws

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1 At I-25 the House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report  
2 3-I-25 for report back at A-26. Because CCB Report 3-I-25 was long and complex, the Council  
3 opted to separate the issues it addressed into several focused reports.

4  
5 This report covers the general parameters that govern the medical student regional delegates and  
6 alternate delegates and resident and fellow sectional delegates and alternate delegates with some  
7 proposed changes for clarity, consistency and accuracy.

## 8 9 BACKGROUND

### 10 11 Specific Requirements of the Medical Student Regional and Resident and Fellow Sectional 12 Delegations

13  
14 The medical student regional delegates and alternate delegates and the resident and fellow sectional  
15 delegates and alternate delegates are governed by long-existing American Medical Association  
16 (AMA) Bylaw provisions. The HOD in granting additional representation to [medical students](#) and  
17 [residents and fellows](#) adopted language prescribing that these representatives must be endorsed by  
18 a society represented in the HOD and be elected by their peers. The bylaws further specify that  
19 medical student regional delegates and alternate delegates require an endorsement from the  
20 constituent society in which their medical school is located and may only represent their [Medical](#)  
21 [Student Region](#), as defined in the Medical Student Internal Operating Procedures. Similarly, there  
22 are limitations on the number of resident and fellow sectional delegates and alternate delegates that  
23 may be elected with endorsement from a single state or specialty, with those details contained in  
24 the rules (internal operating procedures) of the Resident and Fellow Section.

25  
26 Current bylaws also direct that the apportionment of the medical student regional and resident and  
27 fellow sectional delegates and alternates is determined in January but does not take effect until the  
28 following January, one year later. This timing is important as it allows for the election of medical  
29 student regional and resident and fellow sectional delegates to take place in November, in  
30 conjunction with the Interim meeting. These elected delegates are then reported to the Office of the  
31 House of Delegates prior to the development of the HOD seating chart which occurs in January of  
32 each year, directly after the apportionment process for the HOD is completed. Other bylaw  
33 provisions specify that the medical student regional delegates are seated with their endorsing  
34 constituent society and the resident and fellow sectional delegates are seated with their endorsing  
35 society, hence the need to identify elected medical student regional and resident and fellow  
36 sectional delegates prior to developing the HOD seating chart for the year. These seats remain with  
37 the original delegate's endorsing society for the duration of that delegate's term (1 year). Alternate

1 delegates or temporary delegates will be seated in this primary delegate's seat, even if they are  
2 from a different state within the Medical Student Region or from a different state or specialty than  
3 the original resident and fellow sectional delegate. Therefore, the Council moved the existing  
4 language that governs the seating of the medical student regional delegates and the resident and  
5 fellow sectional delegates under the heading for the medical student regional and the resident and  
6 fellow sectional delegations.

7  
8 The bylaw clarifications offered in this report do not change existing rules that govern the  
9 apportionment, election, or seating of the medical student regional or resident and fellow sectional  
10 delegates and alternate delegates. The rules that govern the filling of vacancies or meeting absences  
11 in these positions are discussed in CCB 7.

## 12 13 RECOMMENDATIONS

14  
15 The Council on Constitution and Bylaws recommends that the following Bylaws amendments and  
16 deletions (shown in red and amended by insertion or deletion) be adopted, and that the remainder  
17 of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
18 House of Delegates present and voting following a one-day layover.

19  
20 **2.3 Medical Student Regional Delegates and Alternate Delegates.** In addition to the  
21 delegate and alternate delegate representing the Medical Student Section, medical student  
22 regional delegates and regional alternate delegates shall be apportioned and elected as  
23 provided in this bylaw.

24  
25 **2.3.1 Qualifications.** Medical student regional delegates and alternate delegates must be  
26 active medical student members of the AMA. In addition, medical student regional  
27 delegates and alternate delegates must be members of and have received written  
28 endorsement from ~~their endorsing~~ constituent association where their educational  
29 program is located. The Medical Student Region in which the endorsing society is  
30 located determines the student's region, and a medical student may only serve as a  
31 regional delegate, alternate delegate or any temporary delegate or temporary  
32 alternate delegate form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only for  
33 that region.

34  
35 **2.3.2 Apportionment.** The total number of ~~M~~medical ~~S~~student ~~R~~regional delegates and  
36 alternate delegates is based on one delegate and one alternate delegate for each  
37 2,000 active medical student members of the AMA, as recorded by the AMA on  
38 December 31 of each year. Each Medical Student Region, as defined by the  
39 Medical Student Section, is entitled to one delegate and one alternate delegate for  
40 each 2,000 active medical student members of the AMA in an educational program  
41 located within the jurisdiction of the Medical Student Region. Any remaining  
42 ~~M~~medical ~~S~~student ~~Section R~~regional delegates and alternate delegates shall be  
43 apportioned one delegate and one alternate delegate per region(s) with the greatest  
44 number of active AMA medical student members in excess of a multiple of 2,000.  
45 If two ~~R~~regions have the same number of active AMA medical student members,  
46 ties will be broken by lottery by the Medical Student Section Governing Council.

47  
48 **2.3.2.1 Effective Date.** In January of each year the AMA shall notify the chair of  
49 the Medical Student Section Governing Council and the director of the  
50 Medical Student Section of the number of seats in the House of Delegates  
51 to which each Medical Student Region is entitled. Such apportionment

shall take effect on January 1 of the following year and shall remain effective for one year.

**2.3.3 Election.** Medical student regional delegates and alternates delegates shall be elected by the medical student representatives to the appropriate Medical Student ~~Section~~ Region in accordance with rules ~~procedures~~ adopted by the Medical Student Section and approved by the Board of Trustees. ~~Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees.~~ Regional dDelegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section held in conjunction with prior to the Interim Meeting of the House of Delegates. Regional dDelegates and alternate delegates shall be seated assume office at the subsequent next Annual Meeting meeting of the House of Delegates.

\*\*\*

**2.3.5 Term.** Medical sStudent rRegional delegates and alternate delegates shall be elected for one-year terms ~~and shall assume office on the date set by the Medical Student Section Governing Council.~~

\*\*\*

**2.3.7**

~~**2.10.8**~~ **Medical Student Regional Delegate Seating.** Each medical student regional delegate shall be seated with the student’s endorsing constituent association. Alternate delegates, substitute temporary delegates, or temporary alternate delegates shall be assigned to the original medical student regional delegate's seat location during the time they are seated for the original delegate.

**2.4 ~~Delegates from the Resident and Fellow Sectional~~ Delegates and Alternate Delegates.**

In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

**2.4.1 Qualifications.** ~~Resident and fellow sectional~~ Ddelegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional physician delegates and alternate delegates must be members of and have written endorsement from an their endorsing organization currently seated in the HOD, in a capacity appropriate to their level of training.

**2.4.2 Apportionment.** The apportionment of delegates from the Resident and Fellow Section is one delegate and alternate delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

**2.4.2.1 Effective Date.** In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council and the director of the Resident and Fellow Section of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such

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

**2.4.3 Election.** Resident and fellow sectional ~~D~~delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with rules adopted by the Section and approved by the Board of Trustees. Sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section held in conjunction with the Interim Meeting of the House of Delegates. Sectional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates. ~~Each delegate and alternate delegate must receive written endorsement from a society or organization currently seated in the House of Delegates and in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.~~

\*\*\*

**2.4.5 Term.** Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ shall be elected for one-year terms ~~and shall assume office on the date set by the Resident and Fellow Section Governing Council.~~

\*\*\*

**2.10.9**

**2.4.7 Resident and Fellow Sectional Delegate Seating.** Each ~~delegate from the R~~resident and ~~F~~fellow ~~S~~sectional delegate shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate sectional delegates, substitute temporary delegates, or temporary alternate delegates shall be assigned to the original resident and fellow sectional delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**2.3 Medical Student Regional Delegates and Alternate Delegates.** In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

**2.3.1 Qualifications.** Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the constituent association where their educational program is located. The Medical Student Region in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a temporary delegate or temporary alternate delegate for that region.

**2.3.2 Apportionment.** The total number of medical student regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining medical student regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two Regions have the same number of active AMA medical student members, ties will be broken by lottery by the Medical Student Section Governing Council.

**2.3.2.1 Effective Date.** In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council and the Director of the Medical Student Section of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

**2.3.3 Election.** Medical student regional delegates and alternate delegates shall be elected by the medical student representatives to the appropriate Medical Student Region in accordance with rules adopted by the Medical Student Section and approved by the Board of Trustees. Regional delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section held in conjunction with the Interim Meeting of the House of Delegates. Regional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

\*\*\*

**2.3.5 Term.** Medical student regional delegates and alternate delegates shall be elected for one-year terms.

\*\*\*

**2.3.7 Medical Student Regional Delegate Seating.** Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates, temporary delegates, or temporary alternate delegates shall be assigned to the original medical student regional delegate's seat location during the time they are seated for the original delegate.

**2.4 Resident and Fellow Sectional Delegates and Alternate Delegates.** In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

**2.4.1 Qualifications.** Resident and fellow sectional delegates and alternate delegates must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional delegates and alternate delegates must be members of and have written endorsement from an organization currently seated in the HOD, in a capacity appropriate to their level of training.

**2.4.2 Apportionment.** The apportionment of delegates from the Resident and Fellow Section is one delegate and alternate delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

**2.4.2.1 Effective Date.** In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council and the Director of the Resident and Fellow Section of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

**2.4.3 Election.** Resident and fellow sectional delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with rules adopted by the Section and approved by the Board of Trustees. Sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section held in conjunction with the Interim Meeting of the House of Delegates. Sectional delegates and alternate delegates shall assume office at the subsequent meeting of the House of Delegates.

\*\*\*

**2.4.5 Term.** Resident and fellow sectional delegates and alternate delegates shall be elected for one-year terms.

\*\*\*

**2.4.7 Resident and Fellow Sectional Delegate Seating.** Each resident and fellow sectional delegate shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate sectional delegates, temporary delegates, or temporary alternate delegates shall be assigned to the original resident and fellow sectional delegate's seat location during the time they are seated for the original delegate.

## REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 7-A-26

Subject: HOD Delegate and Alternate Delegate Vacancies and Meeting Absences

Presented by: Jerry P. Abraham, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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1 The House of Delegates (HOD) referred Council on Constitution and Bylaws (CCB) Report 3-I-25  
2 and Resolution 10-I-25 to CCB for a report back at A-26. CCB Report 3-I-25 proposed numerous  
3 bylaw amendments, including deletion of references to substitute delegates and temporary  
4 substitute delegates. In that report, the Council had alternatively proposed the term, “temporary  
5 delegates and alternate delegates,” to denote those individuals who were credentialed to fill an  
6 unfilled seat or a delegation vacancy after the credentialing deadline, which is a uniform 45 days  
7 for all groups with HOD representation. As CCB Report 3-I-25 noted, the distinction between  
8 existing bylaw language that characterized alternate delegates, substitute delegates, substitute  
9 alternate delegates, temporary substitute delegates, and temporary substitute alternate delegate was  
10 confusing.

11  
12 Resolution 10-I-25, submitted by the Medical Student Section (MSS) and the Resident and Fellow  
13 Section (RFS) asked for the following actions:

- 14
- 15 • That our AMA Bylaws be amended to explicitly affirm the ability of the RFS to appoint  
16 substitute resident and fellow sectional delegates and alternate delegates as well as  
17 temporary substitute resident and fellow sectional delegates in accordance with procedures  
18 adopted by the Section as all other delegations to the House of Delegates are able to and  
19 without being held to a higher threshold of election; and  
20
  - 21 • That our AMA Bylaws be amended to explicitly affirm the ability of the MSS to appoint  
22 substitute medical student regional delegates and alternate delegates as well as temporary  
23 substitute medical student regional delegates and alternate delegates in accordance with  
24 procedures adopted by the Section as all other delegations to the House of Delegates are  
25 able to and without being held to a higher threshold of election.  
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### 27 BACKGROUND

28  
29 Alternate delegates are considered active members of their delegation and typically share meeting  
30 duties equally with delegates. While the traditional purpose of an alternate delegate is to be seated  
31 in the House at a delegate’s request, in practice, delegations often routinely seat their alternates for  
32 the portion of the meeting covering a reference committee for which the alternate delegate was  
33 primarily responsible or for other designated times to better allow for this division of labor. Seating  
34 of alternates is accomplished via the exchange of the delegate’s temporary credential (salmon card)  
35 — see CCB Report 3-A-26 (Bylaw 2.0.1.3.2). This standard practice is widely used and understood  
36 by members of the House. However, it should not be confused with the recredentialing of an  
37 alternate delegate as a temporary delegate which is reserved for delegate absences from all or the

1 remainder of a meeting. Furthering this confusion is the fact that all individuals who miss the 45-  
2 day credentialing deadline for the meeting are credentialed as temporary delegates or alternate  
3 delegates for that meeting, even though they may be the duly selected individuals from that HOD  
4 entity.

5  
6 In their testimony on CCB Report 3-I-25 and Resolution 10-I-25, medical students and residents  
7 and fellows cited challenges associated with school, work and family responsibilities, which often  
8 equate to an inability to attend both their Section meeting and an entire HOD meeting. They  
9 mentioned the need to hold a leadership position to secure funding to support their attendance in  
10 whole or in part, and they noted that attending the meeting in an “official capacity” such as a  
11 temporary alternate delegate may allow an excused absence from their training program. The  
12 Council heard that many medical students, residents and fellows stay for the HOD meetings for  
13 mentorship and leadership development opportunities and comprise a pool of potential temporary  
14 alternate delegates who could be appointed rather than elected. The Council noted that these  
15 “extra” medical students and residents and fellows in attendance at meetings are occasionally asked  
16 to fill temporary positions in constituent associations, national medical societies, or other groups  
17 represented in the House for which they are an eligible member. Such situations fully comport with  
18 the AMA Bylaws that allow constituent, national medical specialty society, professional interest  
19 medical associations and other groups autonomy in how to fill positions. The difficulty lies in  
20 credentialing these available individuals to fill unfilled medical student regional or resident and  
21 fellow sectional alternate delegate positions. This stems from long-existing Bylaws that require  
22 medical student regional delegates and alternates and resident and fellow sectional delegates and  
23 alternates to be elected by their respective sections and endorsed by an organization represented in  
24 the HOD.

#### 25 26 EXAMPLES AND TERMINOLOGY

27  
28 As a starting point, the Council discussed at length various scenarios that may occur before and  
29 after the credentialing deadline and proposed some definitions for clarity. These definitions will be  
30 included in the glossary of the Bylaws and cited in the House of Delegates Reference Manual:  
31 Procedures, Policies and Practices:

- 32  
33 • ***Vacancy*** – A vacancy is a permanent loss of a position for the remainder of the term.  
34 Vacancies are addressed throughout the Bylaws where the composition of the HOD is  
35 defined.  
36  
37 • ***Meeting Absence*** – A meeting absence occurs when a credentialed delegate or alternate  
38 delegate is unable to attend a meeting of the HOD, or a portion thereof. A remedy for a  
39 meeting absence is the credentialing of a temporary delegate or temporary alternate  
40 delegate.  
41

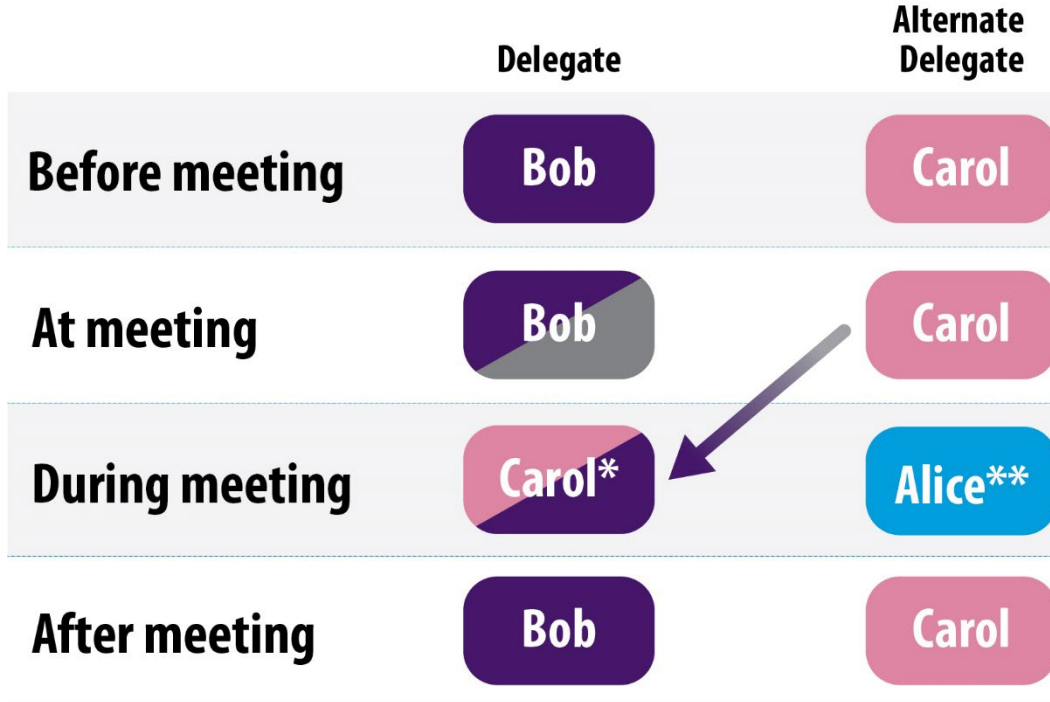
42 **Vacancies** are typically addressed by filling the position via the procedures as defined by the entity  
43 represented in the House of Delegates. This may be via selection of a new individual to complete  
44 the term or to start a new term per the entity’s internal rules.  
45

#### 46 **Example A: *A Medical Association Chooses Bob as its Delegate for a 2-year Term.***

47 Bob duly attends an HOD meeting as a delegate but must resign shortly thereafter. The medical  
48 association then chooses, via its established procedures for filling vacancies, Carol to serve as  
49 delegate for the remainder of Bob’s term.

1 **Meeting Absences** are addressed via the appointment of temporary delegates and temporary  
 2 alternate delegates who fill positions that become open transiently, with the original holder of the  
 3 position expected to fulfill the term. This includes occasions when the duly selected individuals  
 4 were not credentialed by the 45-day credentialing deadline.

5  
 6 **Example B: Bob, the Delegate, Leaves the Meeting.**  
 7 A medical association has chosen Bob as its delegate and Carol as its alternate delegate. They  
 8 are credentialed by the 45-day deadline. Alice, a member of the association and the AMA,  
 9 attends the meeting but is not serving as a delegate or alternate delegate. Bob must leave the  
 10 meeting before it concludes. Carol, the alternate delegate, may function as the delegate using  
 11 Bob’s salmon card, but she may not vote in elections. Alternatively, the medical association  
 12 may choose to recredential her as a temporary delegate. If Carol is recredentialled as a  
 13 temporary delegate, her alternate delegate position opens. This position may be left open or  
 14 may be filled by credentialing a temporary alternate delegate. In this instance, the medical  
 15 association chooses to credential Alice as a temporary alternate delegate for that meeting only.  
 16 Following the meeting, Bob and Carol resume their roles for the remainder of their terms.



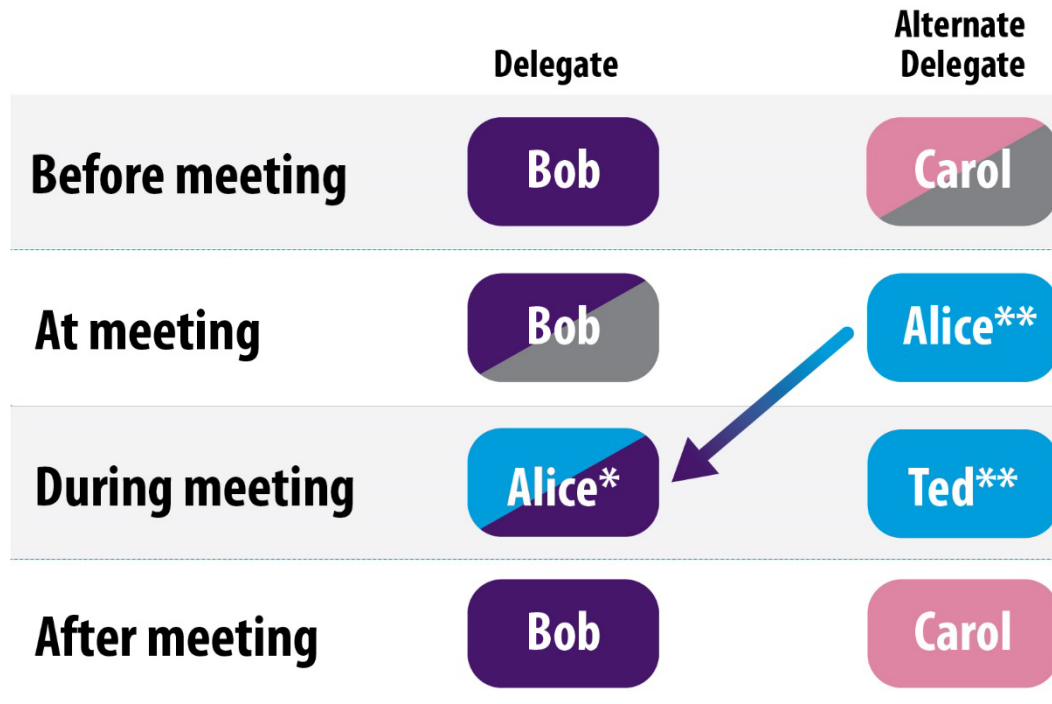
\* Alternate delegate (salmon card) or temporary delegate  
 \*\* Temporary alternate delegate or unfilled

1 **Example C: Carol, the Alternate Delegate, Leaves Meeting.**  
 2 Bob and Carol are the medical association’s credentialed delegate and alternate delegate for an  
 3 HOD meeting, but Carol has to leave the meeting early. Carol’s position may remain unfilled  
 4 for the rest of the meeting or the association may choose to credential Alice as the temporary  
 5 alternate delegate for that meeting only. Following the meeting, Bob and Carol resume their  
 6 roles for the remainder of their terms.

	Delegate	Alternate Delegate
<b>Before meeting</b>	Bob	Carol
<b>At meeting</b>	Bob	Carol
<b>During meeting</b>	Bob	Alice**
<b>After meeting</b>	Bob	Carol

**\*\* Temporary alternate delegate or unfilled**

7 **Example D: Bob Must Leave and Carol is Absent for the Meeting.**  
 8 Bob and Carol are the medical association’s credentialed delegate and alternate delegate for an  
 9 HOD meeting. Carol learns she is unable to attend, so the medical association chooses to  
 10 credential Alice as a temporary alternate delegate. At the meeting, Bob learns he must leave  
 11 urgently. Alice may function as the delegate using Bob's salmon card, but she may not vote in  
 12 elections. Alternatively, the medical association may choose to credential her as a temporary  
 13 delegate. If so, the alternate delegate position could remain unfilled, or the association could  
 14 credential Ted, another eligible association member in attendance, as the temporary alternate  
 15 delegate. Following the meeting, Bob and Carol resume their roles for the remainder of their  
 16 terms.



\* Alternate delegate (salmon card) or temporary delegate

\*\* Temporary alternate delegate or unfilled

1 CONCLUSION

2

3 The Council offers definitions of vacancy and meeting absences to clarify these two instances  
 4 whereby an open seat needs to be permanently versus temporarily filled, along with the protocol to  
 5 fill each. This report also standardizes the terminology governing temporary delegates and alternate  
 6 delegates and clarifies the eligibility order of individuals who may be credentialed in these  
 7 positions.

8

9 Lastly, this report fulfills the request of Resolution 10-I-25 by providing the necessary bylaw  
 10 changes to allow for credentialing by appointment of a temporary medical student regional  
 11 alternate delegate and a temporary resident and fellow sectional alternate.

12

13 RECOMMENDATIONS

14

15 The Council on Constitution and Bylaws recommends that the following Bylaw amendments and  
 16 deletions (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of  
 17 the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
 18 House of delegates present and voting following a one-day layover.

19

20 **2.1.5 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the  
 21 credentialing deadline shall assume office immediately after selection and serve for  
 22 the remainder of that term.

23

24 \*\*\*

1           **2.2.5 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the  
2           credentialing deadline shall assume office immediately after selection and serve for  
3           the remainder of that term.

4           \*\*\*

6           **2.3.6 Vacancies.** ~~A medical student who~~ The delegate selected to fills a vacancy before  
7           the credentialing deadline as a medical student regional delegate or alternate  
8           delegate must be from the same Medical Student Region as the vacating student,  
9           must be endorsed by the appropriate endorsing constituent association, and must be  
10           elected by the appropriate electorate. A medical student regional delegate or  
11           alternate delegate who fills such a vacancy shall assume office immediately after  
12           selection and serve for the remainder of that term.

14           \*\*\*

16           **2.4.6 Vacancies.** ~~A resident or fellow who~~ The delegate selected to fills a vacancy for a  
17           resident and fellow sectional delegate or alternate delegate before the credentialing  
18           deadline must be elected by the Resident and Fellow Section and must be endorsed  
19           by an entity represented in the House of Delegates. A resident and fellow sectional  
20           delegate or alternate delegate who fills a vacancy shall assume office immediately  
21           after selection and serve for the remainder of the term.

22           \*\*\*

24           **2.6.3 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the  
25           credentialing deadline shall assume office immediately after selection and serve for  
26           the remainder of that term.

28           **2.10 Registration and Seating of Delegates. Temporary Delegates and Alternate Delegates.**

30           **2.10.4 Substitute Delegates.**

31           **2.10.1 Temporary Delegates.** The credentialing authority of any entity represented in  
32           the House of Delegates may credential a temporary delegate, who shall be eligible  
33           to serve in the House of Delegates at that meeting only.

35           **2.10.1.1** When there is no delegate credentialed by the 45-day credentialing  
36           deadline, a delegate who was appropriately selected via the entity’s rules  
37           may be credentialed as a temporary delegate, who shall be eligible to  
38           serve in the House of Delegates at that meeting only.

40           **2.10.1.2** When there is no appropriately selected delegate available an alternate  
41           delegate may be credentialed as a temporary delegate, who shall be  
42           eligible to serve in the House of Delegates at that meeting only.

44           **2.10.1.3** When there is no appropriately selected alternate delegate available a  
45           temporary alternate delegate may be credentialed as a temporary  
46           delegate, who shall be eligible to serve in the House of Delegates at that  
47           meeting only.

49           **2.10.1.4** Temporary delegates must be credentialed the day before an AMA  
50           election in order to vote in that election.

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**2.10.2 Temporary Alternate Delegates.** The credentialing authority of any entity represented in the House of Delegates may credential a temporary alternate delegate, who shall be eligible to serve at that meeting only.

**2.10.2.1** When there is no alternate delegate credentialed by the 45-day credentialing deadline, an alternate delegate who was appropriately selected via the entity’s rules may be credentialed as a temporary alternate delegate for that meeting only.

**2.10.2.2** When there is no appropriately selected alternate delegate available, a member of the entity who is also an AMA member may be credentialed as a temporary alternate delegate, who shall be eligible to serve at that meeting only.

**2.10.2.3 Temporary Medical Student Regional Alternate Delegate.** The credentialing authority for the Medical Student Section may credential a member of the Medical Student Section who has a written endorsement from their constituent association and who is from the same Medical Student Region as the absent alternate delegate as a medical student regional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

**2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate.** The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

\*\*\*

~~**2.10.1—Notification.** In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.~~

~~**2.10.2—Credentials.** A delegate or alternate delegate may only be seated if there is certification on file stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.~~

~~**2.10.3—Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective entity is established, and so certified to the AMA.~~

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~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate’s place may be taken during the period of~~

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(Modify Bylaws)

~~absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**2.1.5 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

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**2.2.5 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

\*\*\*

**2.3.6 Vacancies.** A medical student who fills a vacancy before the credentialing deadline as a medical student regional delegate or alternate delegate must be from the same Medical Student Region as the vacating student, must be endorsed by the appropriate endorsing constituent association, and must be elected by the appropriate electorate. A medical student regional delegate or alternate delegate who fills such a vacancy shall assume office immediately after election and serve for the remainder of that term.

\*\*\*

**2.4.6 Vacancies.** A resident or fellow who fills a vacancy for a resident and fellow sectional delegate or alternate delegate before the credentialing deadline must be elected by the Resident and Fellow Section and must be endorsed by an entity represented in the House of Delegates. A resident and fellow sectional delegate or alternate delegate who fills a vacancy shall assume office immediately after election and serve for the remainder of the term.

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**2.6.3 Vacancies.** The delegate or alternate delegate selected to fill a vacancy before the credentialing deadline shall assume office immediately after selection and serve for the remainder of that term.

**2.10 Temporary Delegates and Alternate Delegates.**

/

**2.10.1 Temporary Delegates.** The credentialing authority of any entity represented in the House of Delegates may credential a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

**2.10.1.1** When there is no delegate credentialed by the 45-day credentialing deadline, a delegate who was appropriately selected via the entity's rules may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

**2.10.1.2** When there is no appropriately selected delegate available an alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

**2.10.1.3** When there is no appropriately selected alternate delegate available a temporary alternate delegate may be credentialed as a temporary delegate, who shall be eligible to serve in the House of Delegates at that meeting only.

**2.10.1.4** Temporary delegates must be credentialed the day before an AMA election in order to vote in that election.

- 2.10.2 Temporary Alternate Delegates.** The credentialing authority of any entity represented in the House of Delegates may credential a temporary alternate delegate, who shall be eligible to serve at that meeting only.
- 2.10.2.1** When there is no alternate delegate credentialed by the 45-day credentialing deadline, an alternate delegate who was appropriately selected via the entity's rules may be credentialed as a temporary alternate delegate for that meeting only.
- 2.10.2.2** When there is no appropriately selected alternate delegate available, a member of the entity who is also an AMA member may be credentialed as a temporary alternate delegate, who shall be eligible to serve at that meeting only.
- 2.10.2.3 Temporary Medical Student Regional Alternate Delegate.** The credentialing authority for the Medical Student Section may credential a member of the Medical Student Section who has a written endorsement from their constituent association and who is from the same Medical Student Region as the absent alternate delegate as a medical student regional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.
- 2.10.2.4 Temporary Resident and Fellow Sectional Alternate Delegate.** The credentialing authority for the Resident and Fellow Section may credential a member of the Resident and Fellow Section who has a written endorsement from an entity represented in the House of Delegates as a resident and fellow sectional temporary alternate delegate. This individual shall be eligible to serve at that meeting only.

# REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 8-A-26

Subject: Business Meetings of the AMA Sections

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

Referred to: Reference Committee on Ethics and Bylaws

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1 In preparing its reports for the A-26 meeting of the House of Delegates and in reviewing updates to  
2 Section rules for approval by the Board, the Council has learned that existing AMA Bylaw  
3 language is confusing and constraining when referring to the Business Meetings of the AMA  
4 Sections. Some Sections have multiple business meetings prior to each meeting of the House of  
5 Delegates with components such as a virtual reference committee and elections that are  
6 accomplished electronically.

7  
8 The Council has prepared this report to ensure that the AMA Bylaws remain accurate. An  
9 additional editorial change has been incorporated to reflect Bylaw 7.0.7 that states that “all rules,  
10 regulations, and procedures adopted by each Section shall be subject to the approval of the Board  
11 of Trustees”.

## 12 RECOMMENDATIONS

13  
14  
15 The Council on Constitution and Bylaws recommends that the following Bylaw amendments and  
16 deletions (shown in red and amended by insertion or deletion) be adopted and that the remainder of  
17 the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the  
18 House of Delegates present and voting following a one-day layover.

19  
20 **7.0.6 Business Meeting.** There shall be a Business Meeting of members of each Section. ~~The~~  
21 ~~Business Meeting shall be held on a day~~ prior to each ~~Annual and Interim M~~meeting of the  
22 House of Delegates.

23  
24 **7.0.6.1 Purpose.** The purposes of the Business Meeting shall be:

25  
26 **7.0.6.1.1** To hear such reports as may be appropriate.

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28 **7.0.6.1.2** To consider other business and vote upon such matters as may  
29 properly come before the meeting.

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31 **7.0.6.1.3** To adopt resolutions for submission by the Section to the House of  
32 Delegates.

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34 **7.0.6.1.4** To hold elections.

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**7.0.6.2 Meeting Procedure.**

**7.0.6.2.1** The Business Meeting shall be open to all members of the AMA.

**7.0.6.2.2** Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.

**7.0.6.2.3** The Business Meeting shall be conducted pursuant to rules of procedure adopted by the ~~Governing Council Section~~ and approved by the Board of Trustees. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.

(Modify Bylaws)

**CLEAN BYLAW LANGUAGE IF ADOPTED**

**7.0.6 Business Meetings.** There shall be a Business Meeting of members of each Section prior to each meeting of the House of Delegates.

**7.0.6.1 Purpose.** The purposes of the Business Meeting shall be:

**7.0.6.1.1** To hear such reports as may be appropriate.

**7.0.6.1.2** To consider other business and vote upon such matters as may properly come before the meeting.

**7.0.6.1.3** To adopt resolutions for submission by the Section to the House of Delegates.

**7.0.6.1.4** To hold elections.

**7.0.6.2 Meeting Procedure.**

**7.0.6.2.1** The Business Meeting shall be open to all members of the AMA.

**7.0.6.2.2** Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.

**7.0.6.2.3** The Business Meeting shall be conducted pursuant to rules of procedure adopted by the Section and approved by the Board of Trustees. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 9-A-26

Subject: Continuity of AMA Resident and Fellow Section Governing Council Leadership

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

Referred to: Reference Committee on Ethics and Bylaws

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1 At the 2025 Interim Meeting of the House of Delegates Policy [D-600.950](#) was adopted and called  
2 for an amendment to the AMA Bylaws to allow the section’s Immediate Past Chair to serve in that  
3 position even if they no longer meet the membership definition of either a resident (Bylaw [7.1.1.1](#))  
4 or a fellow (Bylaw [7.1.1.2](#)). Bylaw [7.1.2](#) states that “If any officer or Governing Council member  
5 ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for  
6 which elected, the term of such officer or member shall terminate and the position shall be declared  
7 vacant.” Bylaw 7.1.2 further provides a grace period for a Governing Council member who  
8 completes residency or fellowship within 90 days prior to an Annual Meeting. What 7.1.2 does not  
9 address, however, is an immediate past chair who during their six-month term as a nonvoting ex  
10 officio member and who completes their residency or fellowship between the Annual and the  
11 Interim Meeting. Currently, that Immediate Past Chair would be unable to continue their service on  
12 the RFS Governing Council.

13  
14 The Council presents the appropriate Bylaw changes to allow the Immediate Past Chair to fulfill  
15 their term on the RFS Governing Council.

16  
17 **RECOMMENDATIONS**

18  
19 The Council on Constitution and Bylaws recommends that the following amendments to the  
20 Bylaws (shown in red and amended by [insertion](#) or [deletion](#)) be adopted, that Policy D-600.950 be  
21 sunset, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-  
22 thirds of the members of the House of Delegates present and voting following a one-day layover.

23  
24 **7.1 Resident and Fellow Section.** The Resident and Fellow Section is a fixed Section.

25  
26 **7.1.1 Membership.** All active resident/fellow physician members of the AMA shall be  
27 members of the Resident and Fellow Section.

28  
29 **7.1.1.1 Definition of a Resident.** For purposes of membership in the Resident and  
30 Fellow Section, the term Resident shall be applied to any physicians who  
31 meet at least one of the following criteria:

32  
33 a) Members who are enrolled in a residency approved by the Accreditation  
34 Council for Graduate Medical Education.

35 b) Members who are active duty military or public health service residents  
36 required to provide service after their internship as general medical

1 officers (including underseas medical officers or flight surgeons) before  
2 their return to complete a residency.

3 c) Members who are serving, as their primary occupation, in a structured  
4 educational, vocational, or research program of at least one year to  
5 broaden competency in a specialized field prior to completion of their  
6 residency.

7  
8 **7.1.1.2 Definition of a Fellow.** For purposes of membership in the Resident and  
9 Fellow Section, the term Fellow shall be applied to any physicians who  
10 have completed a residency and meet at least one of the following criteria:

11  
12 a) Members who are serving in fellowships approved by the Accreditation  
13 Council for Graduate Medical Education.

14 b) Members who are serving, as their primary occupation, in a structured  
15 clinical, educational, vocational, or research training program of at least  
16 six months to broaden competency in a specialized field.

17  
18 **7.1.2 Cessation of Eligibility.** If any officer or Governing Council member ceases to  
19 meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the  
20 term for which elected, the term of such officer or member shall terminate and the  
21 position shall be declared vacant. If the officer or member completes residency or  
22 fellowship within 90 days prior to an Annual Meeting, the officer or member shall  
23 be permitted to continue to serve in office until the completion of the Annual  
24 Meeting. An immediate past chair who completes residency or fellowship during  
25 their term as immediate past chair shall be permitted to serve as a nonvoting ex  
26 officio member of the Governing Council for the remainder of their immediate past  
27 chair term.

28  
29 (Modify Bylaws)

30  
31 RELEVANT AMA POLICY

32  
33 D-600.950, Amendment to AMA Bylaws to Enable Continuity of Leadership. Our American  
34 Medical Association will amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section  
35 (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS.

## **CLEAN BYLAW LANGUAGE IF ADOPTED**

**7.1 Resident and Fellow Section.** The Resident and Fellow Section is a fixed Section.

**7.1.1 Membership.** All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

**7.1.1.1 Definition of a Resident.** For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

- a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education.
- b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
- c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

**7.1.1.2 Definition of a Fellow.** For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

- a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education.
- b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

**7.1.2 Cessation of Eligibility.** If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member completes residency or fellowship within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting. An immediate past chair who completes residency or fellowship during their term as immediate past chair shall be permitted to serve as a nonvoting ex officio member of the Governing Council for the remainder of their immediate past chair term.

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-26)  
Guidelines on Chaperones for Sensitive Exams

EXECUTIVE SUMMARY

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 01-A-26

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

3  
4 Our American Medical Association will ask the Council on Ethical and Judicial Affairs to  
5 consider amending E-1.2.4, “Use of Chaperones in the *Code of Medical Ethics*,” to ensure that  
6 it is most in line with the current best practices for adult and pediatric populations and  
7 potentially considers the following topics:

- 8  
9 a. Opt-out chaperones for breast, genital, and rectal exams.  
10 b. Documentation surrounding the use or not-use of chaperones.  
11 c. Use of chaperones for patients without capacity.  
12 d. Asking patients’ consent regarding the gender of the chaperones and attempting to  
13 accommodate that preference as able.  
14 e. Use of chaperone at physician request when physician deems necessary.  
15

16 To fulfil this directive, the Council on Ethical and Judicial Affairs (CEJA) submitted Report 7,  
17 “Guidelines on Chaperones for Sensitive Exams,” for consideration at the 2025 Annual Meeting.  
18 The report was referred with concerns expressed that the report did not adequately address certain  
19 issues such as physician safety, the economic hurdles of training and staffing chaperones, and  
20 challenges related to varying clinical scenarios, such as those posed by rural hospitals. This report  
21 includes recommendations that address these concerns.  
22

### 23 BACKGROUND

24  
25 Conducting sensitive examinations in an ethically and clinically sound manner requires physicians  
26 to be responsive to both the distinctive characteristics of the individual patient and to the  
27 boundaries appropriate to the patient-physician relationship. While a sensitive exam is typically  
28 understood as one involving any examination of, or procedure involving, the genitalia, breasts,  
29 perianal region or the rectum, physicians should be aware that a patient’s personal history,  
30 including their cultural background and beliefs or identity may broaden their definition of what  
31 constitutes a sensitive examination or procedure<sup>1</sup>. Efforts to provide a comfortable and considerate  
32 atmosphere for the patient during sensitive exams are part of respecting patients’ dignity. These  
33 efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of

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

1 draping, and clearly explaining various components of the physical examination. They also include  
2 the use of chaperones regardless of the gender of the physician or patient<sup>2</sup>.

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

12  
13 Having chaperones present can help prevent misunderstandings between the patient and physician  
14 and can protect the integrity of the patient-physician relationship. A fair and effective policy on the  
15 use of chaperones must balance: (1) concern for both physician and patient safety, dignity, and  
16 vulnerability; (2) respect for patient preferences; and (3) the ethical responsibility to maintain clear  
17 professional boundaries.

18  
19 In most instances, only an authorized member of the health care team should serve as a chaperone  
20 and understand the responsibilities of the role. Broadly speaking, chaperones should be provided  
21 with information regarding<sup>18</sup>:

- 22
- 23 • Expected components of the procedures they will be observing;
  - 24 • Ways to ensure patient comfort during the examination or procedure;
  - 25 • Appropriate gowning or draping for privacy;
  - 26 • Suitable positioning in the room such that they can assess the nature of the contact  
27 between physician and patient;
  - 28 • How to intervene or stop an examination or procedure if they are concerned that the  
29 patient is distressed or that inappropriate contact has occurred;
  - 30 • Reporting mechanisms for concerns and non-compliance with established chaperone  
31 policy.
- 32

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

41  
42 The standard approach is to have healthcare staff (such as nurses, medical assistants or physician  
43 assistants) act as chaperones, provided they are fully trained in the responsibilities of the role.  
44 Occupying a dual role as chaperone and member of the care team is acceptable when the two sets  
45 of responsibilities do not conflict and are well understood by everyone involved. "Parents and other  
46 untrained individuals" should not act as chaperones, except in the case of young children<sup>3,17</sup>.

47  
48 Chaperones may feel uncertain or hesitant about intervening during an examination or procedure,  
49 or about reporting misconduct. To establish expectations for the role of chaperones, institutions and  
50 practices should set policies for both physicians and chaperones in advance. They should also agree

1 on methods of communication to signal patient distress or chaperone concerns while examinations  
2 or procedures are in progress<sup>3</sup>.

3  
4 Concerns may arise regarding the additional resources needed to implement current best practices  
5 for the use of chaperones. In particular, physicians may be concerned that these resources will be  
6 diverted away from patient care. Despite these valid concerns, it has been established that “most  
7 patients regard the offer of a chaperone as a sign of respect,” and further, that chaperones can help  
8 minimize physician misconduct, which has significant detrimental effects on patient well-being, the  
9 patient-physician relationship, and the integrity of the profession as a whole<sup>1,10</sup>. In light of these  
10 considerations, limited resources or additional costs do not ethically justify the failure to regularly  
11 employ chaperones for sensitive examinations and procedures, and/or to make them available in  
12 other situations at the patient’s or physician’s request.

### 13 14 ETHICS ISSUES

15  
16 The ethical concerns related to the use of chaperones for sensitive examinations center around the  
17 trust and trustworthiness of the patient-physician relationship. The use of a chaperone is meant to  
18 uphold respect for patients as persons and is intended as a means to recognize and protect patients’  
19 dignity, vulnerability, and autonomy. Chaperones are also important for minimizing risks to  
20 physicians as well, such as verbal or physical harassment. In addition to concerns for patient and  
21 physician safety, the need for chaperones raises other ethical concerns, such as how to  
22 appropriately train, fund, and staff chaperones. This can be particularly challenging in limited  
23 resource settings, such as rural hospitals, highlighting that ethical necessities may at times conflict  
24 with practical realities, and that the need for a chaperone is always contextually situated, making it  
25 difficult to establish clinical guidance that is able to cover all possible scenarios.

### 26 27 DISCUSSION

28  
29 Medical examinations and procedures often require the patient to put aside their norms regarding  
30 modesty and give consent to being heard, seen, and touched in ways they would not usually allow.  
31 Therefore, it is critical to show respect to patients and foster trustworthiness. The presence of a  
32 chaperone reinforces the professional nature of the clinical interaction, with the goal of providing  
33 reassurance that the patient’s experiences and concerns and the boundaries of the clinical encounter  
34 are being respected<sup>1</sup>. Having chaperones present can also help prevent misunderstandings between  
35 patients and physicians by clarifying expectations and facilitating communication about the  
36 examination. Chaperones should be familiar with the elements of sensitive examinations and  
37 procedures, know how to properly observe them, and know when to intervene if they have  
38 concerns. When used in this manner, chaperones may augment a patient’s sense of safety by  
39 assuring the patient that the interventions are appropriate. Additionally, having a third-party present  
40 who can attest to what occurred during the encounter may protect physicians from false allegations  
41 of misconduct<sup>1</sup>.

### 42 43 *Mandatory, Opt-in, and Opt-Out Chaperone Policies*

44  
45 There are three types of chaperone policies: opt-in, opt-out, and mandatory.

- 46  
47 • An opt-in policy is one in which patients are *automatically offered* a chaperone for  
48 sensitive examinations and procedures (the patient is informed that they can request a  
49 chaperone).

- 1 • An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive  
2 examinations and procedures (the patient is provided a chaperone, though the patient is  
3 given the option to decline, so long as the physician agrees a chaperone is not needed).
- 4 • A mandatory policy is one in which a chaperone must be present during all sensitive  
5 examinations or procedures, or else the examination or procedure will not be performed.  
6

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

19  
20 By contrast, under an opt-out policy, patients do not need to make a specific request because the  
21 policy makes it standard practice to have chaperones present for sensitive examinations.  
22 Specifically, chaperones are made available and routinely present during sensitive exams, unless  
23 the patient refuses. Opt-out policies are effective at protecting both the physician and the patient  
24 since, by default, they make it the norm to have a third-party present as a witness to sensitive  
25 exams or procedures.  
26

27 Although the opt-out approach offers patients more protection, in some cases, this approach may  
28 introduce problems with obtaining informed consent. For instance, once a chaperone is brought  
29 into the examination room, a patient may be reluctant to object since this is presented as the usual  
30 way things are done. Some patients also may not realize they have a choice regarding the presence  
31 of a chaperone<sup>13</sup>. Under ordinary circumstances, remaining silent should not be understood as valid  
32 consent.  
33

34 Both opt-in and opt-out policies can create challenges in part because patients’ requests and/or  
35 consent for use of a chaperone take place directly in the treatment room. For this reason, it has been  
36 suggested that patients’ preferences regarding chaperones should be solicited by front desk staff or  
37 other intake staff as a routine part of the check-in procedure<sup>11,4</sup>. This is an opportunity to provide  
38 materials explaining the purpose of the chaperone and to inform patients of the standard policy  
39 while allowing patients to express their preferences in a low-pressure environment. However,  
40 regardless of where and how consent for the use of a chaperone is solicited and obtained,  
41 physicians should keep in mind that what is most important during “the process of obtaining  
42 informed consent is equalizing the patient’s ability to say *yes* or *no*”<sup>6</sup>.  
43

#### 44 *Documentation of Chaperone Use*

45

46 Regardless of the chaperone policy implemented in a particular setting, the medical record should  
47 document the presence or absence of a chaperone for each sensitive examination<sup>1,3,11</sup>. For all  
48 examinations or procedures in which a chaperone is present, the medical record should reflect  
49 whether the patient requested a chaperone explicitly or whether one was present as a matter of  
50 policy. Additionally, the name of the chaperone present and any patient preferences regarding the  
51 use of a chaperone should also be documented. Note that there is a range of acceptable practices for

1 recording chaperone information and therefore, the extent of documentation, including what  
2 precise data to include, varies among medical specialties.

### 3 4 *Patients with Diminished or Lacking Decisional Capacity*

5  
6 It is widely agreed that patients who are unable to give informed consent should always have a  
7 chaperone present for sensitive examinations and procedures. These patients might be unconscious,  
8 sedated, or have cognitive impairments or severe mental illness<sup>9,2,3</sup>. When treating adult patients  
9 who have diminished capacity or lack capacity to consent, it is imperative to have a trusted  
10 companion, social worker, caregiver, or group home escort present alongside the chaperone, to ease  
11 any potential patient distress<sup>3</sup>. It should be made clear that chaperones are mandatory in these  
12 circumstances.

### 13 14 *Patient Preferences Regarding Chaperones*

15  
16 With regard to patients' preference for specific characteristics of a chaperone (such as gender or  
17 religious affiliation), physicians should be respectful of the patient's values and preferences while  
18 also being mindful not to accede to discriminatory or disruptive patient demands. Disrespectful,  
19 derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of  
20 personal preferences on the part of either patients or physicians can undermine trust and  
21 compromise the integrity of the patient-physician relationship while also creating an "environment  
22 that strains relationships among patients, physicians, and the health care team." (Opinion 1.1.2)  
23 Discriminatory requests should not typically be accommodated, and accommodation should only  
24 occur after careful weighing of the circumstances. Patients' preferences, if nondiscriminatory,  
25 should be respected, documented, and upheld within reason and feasibility.

### 26 27 *The Use of a Chaperone at Physician Request*

28  
29 There may be times when the physician deems the use of a chaperone necessary. In such cases, if  
30 the patient declines, the American College of Obstetricians and Gynecologists (ACOG) suggests  
31 that the physician should explain that "the chaperone is an integral part of the clinical team whose  
32 role includes assisting with the examination and protecting the patient and the physician. Any  
33 concerns the patient has regarding the presence of a chaperone should be elicited and addressed if  
34 feasible"<sup>1</sup>. Ideally, these conversations will be a process of joint decision-making between the  
35 patient and the physician. If the patient declines a chaperone when the physician determines having  
36 a chaperone present is clinically indicated, every effort should be made to accommodate the  
37 preferences of the patient, consistent with the requirements of patient safety, physician safety, and  
38 the maintenance of professional boundaries. Physicians should inquire about specific concerns the  
39 patient may have and suggest ways these might be addressed in a mutually acceptable manner.  
40 Physicians should engage the patient in a detailed discussion of how care might be provided in a  
41 way that maintains a comfortable and respectful environment before deciding that they cannot  
42 perform the exam or procedure. If the examination is ultimately performed without the use of a  
43 chaperone, the rationale should be documented<sup>1</sup>. As a last resort, if the patient and physician cannot  
44 come to an agreement, then the physician may defer the examination or procedure and refer the  
45 patient to another clinician. In this situation, patients should be provided with "reasonable  
46 assistance in making alternative arrangements" so they can receive care in a timely fashion  
47 (Opinion 1.1.3).

1 *The Use of a Chaperone without Patient Consent in Exceptional Circumstances*

2  
3 In some situations, insisting on a chaperone when the patient declines may violate the patient's  
4 autonomy and therefore be impermissible. However, physicians may proceed with the use of a  
5 chaperone without the expressed consent of the patient in the following circumstances:

- 6  
7
  - When it is an emergency and failure to proceed rapidly would result in an immediate risk  
8 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  
9 patient's behavior compromises (or has previously threatened or crossed) professional  
10 boundaries, or the physician has reason to believe such a boundary violation or other  
11 unsafe situation is likely to occur.<sup>14</sup>

12  
13

14 *Pediatric & Adolescent Patients*

15  
16 Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from  
17 adult patients because they have different needs and sensitivities. Normally, a parent or guardian  
18 may act as the chaperone for young pediatric patients (from newborns to age 11)<sup>15</sup>. In cases where  
19 a parent or guardian is unavailable or their presence would interfere with the examination (such as  
20 in cases of suspected abuse), another chaperone should be present<sup>15</sup>. Should a parent or guardian  
21 decline the physician's request that a chaperone be present in such situations, it may nevertheless  
22 be appropriate for the physician to insist that a chaperone be present for the sake of patient safety.  
23

24 Addressing the needs of adolescent patients (age 12-17) is more complex. Since many adolescents  
25 are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for  
26 increased privacy," any examination that requires them to remove their clothes could be  
27 distressing<sup>12</sup>. Physicians should not assume that their own definitions of a sensitive examination  
28 reflect the understanding of the individual teenage patient<sup>16</sup>. Research shows that 60-70 percent of  
29 female adolescents would like the option of a chaperone for both standard and sensitive  
30 examinations. Only 21 percent indicated that they would ask for a chaperone if one was not  
31 offered, and substantially more female adolescents wanted a chaperone for sensitive examinations  
32 if they had a chaperone in the past<sup>12</sup>.  
33

34 Many adolescents want a parent to act as chaperone instead of a healthcare professional, although  
35 in general as their age increases their preference for a non-parent chaperone also increases<sup>16</sup>. Some  
36 adolescents do not wish to have chaperones, indicating that it would be more embarrassing,  
37 awkward, or uncomfortable to have an additional person in the room<sup>11</sup>.  
38

39 As such, when treating adolescents, the best policy is to explain the role of chaperone in detail and  
40 then solicit their preferences. It is also important to ask whether they wish to have their family  
41 member or guardian in the room, either in addition to, or instead of, the healthcare professional  
42 acting as chaperone. Since adolescents may not have prior experience with chaperones, it is  
43 probably not sufficient to have them fill out a form at intake. Instead, their options should be  
44 presented during a conversation (and, if they wish, with a parent or guardian present) so a decision  
45 can be made together. Their preferences are also likely to change over time, so this conversation  
46 will need to be revisited.  
47

48 As noted in Opinion 2.2.1 "Pediatric Decision Making," the "more mature a minor patient is [...] the  
49 stronger the ethical obligation to seek minor patients' assent." This obligation extends to their  
50 assent for the presence of a chaperone, as well as their preferences for who the chaperone will be  
51 and the gender of the chaperone. In general, physicians and parents/guardians should respect a

1 minor's refusal to assent to a chaperone (except under the exceptions outlined above when a  
2 physician may either insist or may decline to proceed with the examination for emergency or safety  
3 reasons).  
4

5 Policies around the use of chaperones for adolescents are separate from issues of parental consent  
6 for treatment. Physicians should be aware that in some jurisdictions, "the law permits minors to  
7 receive confidential services relating to contraception, or to pregnancy testing, prenatal care and  
8 delivery services" or to prevent, diagnose, or treat sexually transmitted disease without parental  
9 consent and/or notification (Opinion 2.2.2). Once the legally required consent has been obtained,  
10 the minor patient's preferences concerning use of chaperones can be discussed<sup>17</sup>.  
11

## 12 ETHICS ANALYSIS

13

14 There is a power imbalance embedded in the patient-physician relationship. Patients make  
15 themselves vulnerable to the physician both by permitting procedures and examinations to be  
16 conducted on their bodies and by disclosing private information to the physician during the course  
17 of the clinical encounter. The physician guides the care that the patient receives and should adopt  
18 practices within the clinical encounter to foster trustworthiness. The presence of a trained  
19 chaperone during sensitive examinations contributes to establishing trust between physician and  
20 patient, as knowing that the encounter has been witnessed provides everyone involved with  
21 reassurance that the encounter was professional and safe.  
22

23 Appropriate use of chaperones during sensitive examinations and procedures is meant to protect  
24 both the physician and the patient. Having a chaperone present can increase trust between the  
25 physician and patient, contribute to the comfort and safety of the patient, and help maintain the  
26 patient's dignity. The use of chaperones can also help protect the physician against accusations of  
27 misconduct that arise from misunderstandings or that are intentionally false.  
28

29 Chaperones are responsible for upholding the patient's privacy and confidentiality; however,  
30 because physicians are obligated to "seek to protect privacy in all settings to the greatest extent  
31 possible" (Opinion 3.1.1), opportunities should be provided for private conversation with the  
32 patient without the chaperone present. In addition, physicians should minimize inquiries or taking a  
33 patient's history during a chaperoned examination or procedure. If a patient shares information  
34 with the chaperone that is relevant to patient care but requests that this not be disclosed to the  
35 physician, the chaperone should make it clear that they cannot maintain confidentiality when doing  
36 so would endanger the health of the patient. The chaperone may also encourage the patient to either  
37 raise the issue with the physician themselves or obtain permission from the patient to communicate  
38 the information to the physician separately.  
39

40 What is considered a sensitive examination or procedure can vary widely among patients. In order  
41 to foster trust between the patient and physician and to set appropriate professional boundaries for  
42 sensitive examinations and procedures, various factors affecting the particular patient should be  
43 considered, including history of trauma, sexual orientation, gender identity, personal beliefs, and  
44 cultural norms and expectations.  
45

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

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

9  
10 The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate  
11 behavior<sup>1</sup>. Patients may be more comfortable with someone of a particular gender being present  
12 because that person can better understand the kinds of embarrassment or discomfort associated  
13 with their sensitive exam and so may be better equipped to provide support<sup>8</sup>.

14  
15 While opt-in chaperone policies have historically been regarded as adequate, this is no longer the  
16 case for some specialties. There is evidence that a shift to opt-out policies will better protect both  
17 patients and physicians in many settings. ACOG argues that given "the profoundly negative effect  
18 of sexual misconduct on patients and the medical profession and the association between  
19 misconduct and the absence of a chaperone" regular use of chaperones is necessary to assure  
20 patients and the public that significant "efforts are being made to create a safe environment for all  
21 patients"<sup>1</sup>. Because physician misconduct undermines the integrity of the profession as a whole,  
22 there is strong reason to adopt policies that reduce it. Similarly, the American College Health  
23 Association supports the adoption of opt-out chaperone policies and recommends that every  
24 medical institution have a policy regarding sensitive examinations "to protect patients' safety and  
25 minimize risk associated with the performance of these exams" that should include the presence of  
26 a chaperone for such exams<sup>18</sup>.

27  
28 Physicians deserve to work in an environment where false allegations of misconduct or  
29 misunderstandings between physicians and patients do not compromise either their professional  
30 reputation or the relationships of trust that they have established with their patients. Likewise,  
31 patients deserve to be treated in an environment that supports their agency and improves the quality  
32 of their experience, without being expected to make a special request. These goals are best  
33 promoted through the implementation of an opt-out policy for the use of chaperones during  
34 sensitive exams. Therefore, the presence of chaperones should be standard during sensitive exams  
35 and procedures. In other situations, it is recommended that chaperones be made available if the  
36 patient requests one. While not mandatory for every clinical encounter, patients should be made  
37 aware that they have a right to request a chaperone for any examination. Finally, physicians should  
38 honor patients' preferences for a chaperone even when a trusted companion is present.

## 39 40 CONCLUSION

41  
42 Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures  
43 have evolved in recent years. New standards specify that the use of chaperones should be standard  
44 for all sensitive exams and procedures and that chaperones should be made available in all  
45 situations when the patient requests one. Use of chaperones should not be influenced by the gender  
46 of the physician or patient. Chaperones should receive information regarding the responsibilities of  
47 their role, and patient preferences concerning chaperones should be documented. Chaperones must  
48 be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with  
49 ethics guidance and without fear of retaliation. Reporting mechanisms that do not expose  
50 chaperones to retaliation must also be established in order for the new standards to serve the  
51 purpose of protecting both the physician and the patient. As far as possible, lines of authority in the

1 reporting process should be removed from the immediate employment and clinical supervisory  
2 hierarchy of the reporter<sup>3</sup>. Multiple pathways for patient reporting should be established, including  
3 an anonymous option, and this information should be communicated clearly to patients. When a  
4 patient reports a concern about misconduct, this must not adversely affect their care. While there  
5 are valid concerns related to funding, training, and staffing chaperones, these challenges do not  
6 supersede the ethical obligation to provide a chaperone to patients during sensitive examinations  
7 and procedures. If physicians feel that they cannot uphold this ethical obligation, they should work  
8 with their administrators and specialty associations to remedy the situation.

9  
10 RECOMMENDATION

11  
12 The Council on Ethical and Judicial Affairs recommends the following be adopted and the  
13 remainder of the report be filed:

- 14  
15 1. Opinion 1.2.4 “Use of Chaperones” be amended by deletion and addition as follows:

16  
17 Chaperones should be authorized members of the health care team. All chaperones should  
18 understand the responsibilities of the role and be aware of mechanisms for reporting  
19 unprofessional conduct in keeping with ethics guidance and without fear of retaliation.  
20 Physicians should establish clear expectations that chaperones will uphold professional and  
21 legal standards of privacy and confidentiality.

22  
23 Respecting patient boundaries and promoting patient dignity requires providing a safe and  
24 therapeutic clinical encounter during sensitive examinations and procedures while also  
25 empowering patients. Efforts to provide a comfortable and considerate atmosphere for the  
26 patient and the physician are part of respecting patients’ dignity. Such ~~These~~ efforts may  
27 include measures that promote patient privacy, such as providing appropriate gowns,  
28 private facilities for undressing, sensitive use of draping, clearly explaining various  
29 components of the physical examination, and the use of having a chaperone available.  
30 While a sensitive exam is typically understood as one involving any examination of, or  
31 procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should  
32 be aware that a patient’s personal history, beliefs or identity may broaden their definition  
33 of what constitutes a sensitive examination or procedure.

34  
35 Having a chaperones present also during a sensitive exam helps protect the integrity of the  
36 patient-physician relationship ~~prevent misunderstandings between patient and physician.~~  
37 Physicians should, as always, be mindful of any applicable legal or regulatory  
38 requirements regarding the use of chaperones. Additionally, Physicians should:

- 39  
40 (a) Provide a chaperone for all sensitive exams, regardless of patient capacity, unless the  
41 delay in obtaining a chaperone would result in significant harm to the patient.  
42  
43 (b) Allow patients to decline the presence of a chaperone, unless the physician deems a  
44 chaperone necessary for the exam.  
45  
46 i. If the patient and physician cannot come to an agreement, then the physician may  
47 defer non-emergent examinations or procedures and refer the patient to another  
48 clinician.  
49  
50 ii. In emergency situations, the physician may proceed in providing care with the  
51 presence of a chaperone and document the rationale.

- 1 ~~(e) Have an authorized member of the health care team serve as a chaperone. Physicians~~  
2 ~~should establish clear expectations that chaperones will uphold professional standards~~  
3 ~~of privacy and confidentiality.~~  
4  
5 ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~  
6  
7 ~~(e)(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is~~  
8 ~~present.~~  
9  
10 (d) Make a reasonable effort to accommodate the expressed preferences of the patient  
11 regarding the characteristics of their chaperone, consistent with the interests of  
12 patients, physicians, and the maintenance of professional boundaries.  
13  
14 (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a  
15 parent or guardian is unavailable, or their presence may interfere with the examination,  
16 another chaperone should be present. For adolescent patients, it is appropriate to use a  
17 chaperone either in addition to, or instead of, a family member or guardian as  
18 determined during shared decision making between patient and physician.  
19  
20 All outpatient practices and inpatient services should have a policy regarding sensitive  
21 examinations and procedures that includes the use of chaperones to protect patients and  
22 minimize risk.  
23  
24 For non-sensitive examinations and procedures, patients may request a chaperone, and  
25 reasonable efforts should be made to make one available upon request.  
26  
27 (Modify HOD/CEJA Policy)  
28  
29 2. Policy D-140.950 be rescinded as it has been accomplished by this report. (Rescind AMA  
30 Policy)

Fiscal Note: minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 02-A-26

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

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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1 AMA policy [D-140.946](#), “Managing Conflict of Interest Inherent in New Payment Models,”  
2 adopted at the 2025 Annual Meeting, and asks the following:

3  
4 Our AMA will produce a report with the aim of updating our *Code of Medical Ethics* to  
5 include guidance on disclosure of financial arrangements between physicians and healthcare  
6 facilities, employers, or payors that are potentially against patients’ best interests.

7  
8 This report is submitted for the information of the House of Delegates in fulfillment of the above  
9 directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues  
10 related to physician disclosure of financial arrangements.

11  
12 BACKGROUND

13  
14 Health care in the United States is currently undergoing a transition in the way systems approach  
15 payment and reimbursement for health care services. While, traditionally, health care payment has  
16 been based on the volume of services provided (fee-for-service models), alternative models of  
17 payment (such as value-based care models) are increasingly being adopted throughout the U.S. due  
18 to concerns regarding the lack of equity and focus on patient-centered care that has become  
19 endemic with fee-for-service models.<sup>1</sup> Many health care organizations welcome this transition,  
20 though proponents of fee-for-services models assert that value-based care also has issues and that  
21 we are better off realigning incentives within fee-for service models.<sup>2</sup> Other major shifts in the  
22 health care payment landscape include the rise of venture capital and private equity firms’  
23 increasing investment in, and acquisition of, physician practices and hospitals;<sup>3</sup> new and emerging  
24 technologies, such as personalized medicine and the use of AI tools within medicine, which are  
25 adding new complications to financial and reimbursement models;<sup>4,5</sup> and payments to physicians  
26 from industry, which remain pervasive despite evidence that such payments may influence clinical  
27 decision-making and negatively impact trust in the patient-physician relationship (though payments  
28 vary widely both within and between specialties).<sup>6</sup> As financial arrangements between physicians  
29 and healthcare facilities, employers, and payors continue to evolve, physicians must strive to  
30 ensure that such payment models and financial incentives do not conflict with or prohibit them  
31 from upholding their ethical and professional obligations to patients.

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## 1 ETHICS ISSUES

2  
3 Physicians have an ethical obligation to prioritize patient welfare over financial incentives; thus,  
4 payment models potentially create dual loyalties and conflicts of interest if they encourage  
5 physicians to prioritize costs and revenue over patient care. A primary mechanism to protect  
6 patients, physicians, and trust in the institution of medicine is through the disclosure of any  
7 financial arrangements or other similar factors that could impact patient care. As payment models  
8 and financial arrangements become increasingly complex and challenging for patients to  
9 understand, there is an ever greater need for physicians to be aware of and understand their ethical  
10 obligations related to the appropriate disclosure of these financial arrangements, including how to  
11 uphold professionalism, informed consent, transparency, and quality care.

12  
13 ETHICS ANALYSIS & RELEVANT *CODE* OPINIONS

14  
15 The AMA's *Code of Medical Ethics* is not blind to the potential dangers posed by payment models  
16 and financial incentives. Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges  
17 that such models "can create conflicts of interest among patients, health care organizations, and  
18 physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are  
19 not individualized for the particular patient."<sup>7</sup> The opinion provides specific guidelines for  
20 physicians in leadership positions within health care organizations, and for the profession as a  
21 whole, on how organizational structures, payment models, and decision-support tools should be  
22 implemented to minimize the risk of unethical behavior.

23  
24 The *Code* includes several other opinions that provide guidance to physicians related to financial  
25 arrangements and the importance of disclosing such arrangements. Opinion 11.2.2, "Conflicts of  
26 Interest in Patient Care," states that physicians must never "place their own financial interests  
27 above the welfare of their patients" and that regardless of the economic interests of any health care  
28 entity, if such interests "are in conflict with patient welfare, patient welfare takes priority."<sup>8</sup> This  
29 foundational ethical obligation of physicians to prioritize patient care over profits is echoed in  
30 Opinion 11.2.3, "Contracts to Deliver Health Care Services."<sup>9</sup> The opinion includes  
31 recommendations for physicians to thoroughly review contract terms, avoid conflicts of interest,  
32 ensure financial stability, maintain clinical independence, and ensure transparency.

33  
34 With regards to the importance of maintaining transparency, Opinion 11.2.4, "Transparency in  
35 Health Care," states that "physicians have an obligation to inform patients about all appropriate  
36 treatment options, the risks and benefits of alternatives, and other information that may be  
37 pertinent, including the existence of payment models, financial incentives, and formularies."<sup>10</sup> The  
38 opinion also states that physicians should "[d]isclose any financial and other factors that could  
39 affect the patient's care."<sup>10</sup> In essence, this opinion makes it clear that financial disclosure,  
40 including disclosure of payment models or other financial incentives that may impact patient care,  
41 is a fundamental ethical responsibility for physicians. Additionally, the notion regarding the  
42 importance of disclosure is supported by Opinion 2.1.1, "Informed Consent," which highlights the  
43 value of transparent communication in fostering trust and shared decision-making. Taken together,  
44 these opinions require that physicians inform patients of all medically appropriate treatment  
45 options and that they disclose existing financial incentives or payment models that impact care  
46 decisions.<sup>11</sup>

1 CONCLUSION

2

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

9

10 RECOMMENDATION

11

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

Fiscal Note: Minimal

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REPORT 03 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-26)  
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

EXECUTIVE SUMMARY

In adopting Policy H-405.946, “Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization,” the House of Delegates requested that the Council on Ethical and Judicial Affairs (CEJA) “review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.”

Although not all collective actions by physicians may impact clinical practice, the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible. The ethical dilemma is whether physicians can prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit. To respond to these issues, CEJA recommends amending Opinion 1.2.10, “Political Action by Physicians,” to more clearly articulate that disruptive collective actions that would likely harm patients are to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions may be considered if non-disruptive actions fail, though such actions should not directly compromise patient care and the aim of such actions should be to improve patient care and not primarily for physician self-interest.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 03-A-26

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

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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1 Council on Ethical and Judicial Affairs (CEJA) Report 8, “Supporting Efforts to Strengthen  
2 Medical Staffs Through Collective Actions and/or Unionization,” was introduced by CEJA at the  
3 2025 Annual Meeting and was referred. CEJA Report 08-A-25 responded to Policy H-405.946,  
4 “Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or  
5 Unionization,” which was adopted at the 2023 Annual Meeting and asks the following:

- 6
- 7 1. Our American Medical Association will reevaluate the various efforts to achieve collective  
8 actions and/or unionization for physicians nationally.
- 9
- 10 2. Our AMA will request CEJA to review the advisory restricting collective action in section  
11 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians  
12 who have exhausted other non-disruptive methods for reform.
- 13

14 The House testified against the word “could” in recommendation (c) of CEJA Report 8-A-25,  
15 noting that its use is too broad, nonspecific, and might restrict physicians’ ability to take collective  
16 action. CEJA appreciates that the use of “could” created an insurmountable bar, and so as a result,  
17 in recognition of physicians’ fiduciary duties and the need for physician advocacy, CEJA has  
18 reached a balance by changing “could” to “would likely” in recommendation (c) for greater clarity.  
19 At the 2025 Interim Meeting, the House again referred the report and voiced comments directing  
20 CEJA to edit specific language, this time requesting that the use of “could” in recommendation (e)  
21 be amended to mirror the new language of “would likely” in recommendation (c).

22

23 While in the I-25 report, recommendation (c) pertains to all forms of collective actions,  
24 recommendation (e) is specific to disruptive collective actions that could directly compromise  
25 patient care. This report defines a disruptive collective action by physicians as any collective action  
26 that disrupts the day-to-day workflow of physicians within the health care systems in which they  
27 practice. Disruptive collective actions are thus more likely than non-disruptive actions to cause  
28 harm to patients and therefore necessitate a higher ethical burden to be justified, as outlined in  
29 recommendations (d) and (e). The Council has discussed the different language used in the I-25  
30 report recommendations and believes that the use of “could directly” in recommendation (e) best  
31 describes the reality of disruptive collective actions and correctly reflects physicians’ ethical  
32 obligations. However, to help clarify this hierarchy of ethical burden, recommendations (c), (d),  
33 and (e) of the I-25 report have been reorganized as subsections i, ii, and iii, respectively, under

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1 recommendation (b) in this report. Recommendation (e), now iii, has also been revised to better  
2 reflect physicians' primary ethical obligation to patient welfare (ahead of other considerations  
3 including their own self-interest or obligations to others) and the potential for disruptive collective  
4 actions that could directly compromise patient care to interfere with this duty. The Council also  
5 wishes to highlight that the use of "should" is not a prohibition and does not mean physicians must  
6 never engage in such actions. The recommendations presented in this report do not prohibit  
7 physicians from striking but rather lay out the ethical obligations under which such disruptive  
8 collective actions could take place.

## 9 10 BACKGROUND

11  
12 The consolidation of hospitals and physician practices in recent years has led to a shift in the  
13 practice of medicine away from the independent practice model to one in which physicians  
14 increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were  
15 directly employed by hospitals, with 23.4 percent of physician-owned practices having some  
16 hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were  
17 employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8  
18 percent employed by other corporate entities.<sup>1</sup> Paralleling this increase in corporate intrusion into  
19 medicine has been the rise of unionization within the profession. While the number of physicians  
20 who are members of a union is relatively small, and mostly among house officers, their ranks saw  
21 an approximately 26 percent increase in just five years from 2014–2019.<sup>2</sup> As of 2021, an estimated  
22 5.9 percent of practicing physicians were union members, with union contracts covering 8.1  
23 percent of practicing physicians.<sup>1</sup> Currently, two of the main physician unions are the Federation of  
24 Physicians and Dentists and the Union of American Physicians and Dentists.

25  
26 As the financing, organization, and leadership of the health care system change, the practice  
27 environment increasingly makes it challenging for physicians to provide the kind of care patients  
28 want and deserve. Physicians are now increasingly held to strict performance metrics that many  
29 feel are more about meeting corporate financial goals than they are about providing quality patient  
30 care. As a recent New York Times article puts it, "longer-term consolidation of health care  
31 companies has left workers feeling powerless in big bureaucracies. They say the trend has left them  
32 with little room to exercise their professional judgment."<sup>3</sup> There is a growing sense among  
33 physicians that current working conditions are increasingly compromising the patient–physician  
34 relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and  
35 retirement from medicine.

36  
37 Unions are seen by some as a mechanism for physicians to exert influence on corporate health  
38 systems where physicians have less autonomy than in private practices.<sup>4</sup> Unions' power for  
39 collective bargaining comes from their ability to organize members to take collective action.  
40 Unionization, however, is not the only means by which physicians can organize and take collective  
41 action. Hospitals' organized medical staff has been a means by which physicians have exercised  
42 authority over decision making and culture, but the authority and scope of responsibility of the  
43 organized medical staff has been limited.<sup>5</sup> While employed physicians in large systems have not  
44 typically explored re-invigorating the organized medical staff, this remains an alternative means by  
45 which physicians can reclaim lost authority and exercise collective action.<sup>5</sup>

46  
47 Physicians may undertake many forms of collective action, both in the public arena and within  
48 health care institutions. Public actions include, but are not limited to, public advocacy, media  
49 campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting  
50 increasingly are being considered as additional forms of collective action, particularly to effect  
51 change in specific clinical environments. Some of these are not disruptive, such as negotiation with

1 administrators. Disruptive actions are also being considered, such as picketing, refusal to comply  
2 with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A  
3 primary concern surrounding the use of these disruptive collective actions by physicians in the  
4 clinical setting is that some of these actions may impact patient care and thus be in direct conflict  
5 with physicians' professional and ethical duties to not abandon patients and to prioritize patient  
6 care above self-interest.<sup>6</sup>

#### 7 8 *Relevant Laws*

9  
10 In 1935, Congress passed the [National Labor Relations Act](#) (NLRA), amended in 1947 through the  
11 [Taft-Hartley Act](#), which guarantees private sector employees the right to unionize, engage in  
12 collective bargaining, and take collective actions such as strikes.<sup>1</sup> The NLRA covers most private  
13 sector employees but does not cover independent contractors, supervisors, or managers. Part-time  
14 physicians working as independent contractors, physicians in private practice, and physicians  
15 considered to serve a supervisory role, such as medical directors or tenured medical faculty, are  
16 currently excluded.<sup>2</sup>

17  
18 When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit  
19 hospitals, it added Section 8(g), requiring health care employee unions to give at least a ten-day  
20 notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to  
21 make appropriate arrangements for the continuity of patient care in the event of a work stoppage.<sup>2</sup>

22  
23 Laws prohibiting the corporate practice of medicine are an under-appreciated mechanism for  
24 physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s  
25 that prohibit the corporate practice of medicine, but little attention has been paid to the potential  
26 use of such laws to prevent health care institutions from infringing upon the clinical decision-  
27 making authority that properly belongs to physicians.<sup>7</sup>

#### 28 29 *Relevant AMA Policy Provisions*

30  
31 In 2019, the AMA modified two relevant policies: [H-385.973](#) "Collective Negotiations" and [H-385.976](#)  
32 "Physician Collective Bargaining."<sup>8,9</sup> Both support the right of physicians to engage in  
33 collective bargaining and express the AMA's commitment to work for the expansion of which  
34 physicians are eligible for that right under federal law. This includes supporting efforts to narrow  
35 the definition of supervisors such that more physicians are protected under the NLRA.  
36 Though not policy, the AMA's Advocacy Resource Center has also issued a recent [Issue Brief](#):  
37 "Collective bargaining for physicians and physicians in training" that outlines AMA policy on  
38 physician unions and collective bargaining, including the interpretation that the AMA's position is  
39 that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare  
40 circumstances, individual or grassroots actions, such as brief limitations of personal availability,  
41 may be appropriate as a means of calling attention to needed changes in patient care."<sup>2</sup>

#### 42 43 *Relevant Code Provisions*

44  
45 The AMA *Code of Medical Ethics* [Opinion 1.1.1](#), "Patient-Physician Relationships," states that the  
46 core tenets of the clinical encounter for the physician are "to place patients' welfare above the  
47 physician's own self-interest or obligations to others, to use sound medical judgment on patients'  
48 behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the  
49 primary ethical duties of physicians to prioritize patient care and regard their responsibility to the  
50 patient as paramount. The [Principles](#) enumerated in the Code also indicate that such duties extend

1 beyond the bedside and that physicians have a responsibility to seek changes to laws that are  
2 contrary to the best interests of the patient.

3  
4 [Opinion 1.2.10](#), “Political Action by Physicians,” currently states that not only *can* physicians seek  
5 to change policies or laws that they find contrary to the best interest of patients but they in fact  
6 *have* an ethical duty to do so, though they also “have a responsibility to do so in ways that are not  
7 disruptive to patient care.”<sup>10</sup> While the opinion states that “[s]trikes and other collective actions  
8 [...] should not be used as a bargaining tactic”, it also adds that “[i]n rare circumstances, briefly  
9 limiting personal availability may be appropriate as a means of calling attention to the need for  
10 changes in patient care.”<sup>10</sup> However, this permissibility must be balanced by the opinion’s first  
11 directive that physicians participating in advocacy activities should “[e]nsure that the health of  
12 patients is not jeopardized and that patient care is not compromised.”<sup>10</sup>

13  
14 This is in line with [Opinion 1.1.6](#), “Quality,” which states that “[a]s professionals dedicated to  
15 promoting the well-being of patients, physicians individually and collectively share the obligation  
16 to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and  
17 equitable.”<sup>11</sup> Taken together, by stating that “physicians have an ethical responsibility to seek  
18 change” at times ([Opinion 1.2.10](#)) and that they also have an “obligation to ensure” quality care  
19 ([Opinion 1.1.6](#)), these opinions highlight the fact that certain conditions may arise that actually  
20 demand action be taken by physicians to improve patient care.

21  
22 [Opinion 9.3.1](#), “Physician Health & Wellness,” similarly outlines that physicians have a  
23 responsibility to take action when their own health or wellness is compromised.<sup>12</sup> The opinion  
24 stipulates that physicians have a responsibility both individually and collectively to ensure and  
25 promote health and wellness among physicians, and that when their health or wellness is  
26 compromised, individual physicians should fulfill this responsibility by “taking measures to  
27 mitigate the problem.”<sup>12</sup> Physician health and wellness is necessary for effective healing and the  
28 provision of quality care, and collective action may be an appropriate means of securing  
29 institutional conditions that are conducive to patient health and well-being.

### 30 31 *Additional Relevant Policy*

32  
33 The World Medical Association recommends that physicians adopt the following guidelines  
34 regarding collective action:

- 35  
36 1. Physicians who take part in collective action are not exempt from their ethical or  
37 professional obligations to patients.
- 38 2. Even when the action taken is not organized by or associated with the Constituent  
39 Member, the Constituent Member should ensure that the individual physician is aware of  
40 and abides by their ethical obligations.
- 41 3. Whenever possible, physicians should press for reforms through non-violent public  
42 demonstrations, lobbying and publicity or informational campaigns, and/or through  
43 negotiation or mediation.
- 44 4. If involved in collective action, Constituent Members should act to minimize the harm to  
45 the public and ensure that essential and emergency health services, and the continuity of  
46 care, are provided throughout a strike. Further, Constituent Members should advocate for  
47 measures to review exceptional cases. If involved in collective action, Constituent  
48 Members should provide continuous and up-to-date information to their patients and the  
49 general public with regard to the demands of the conflict and the actions being  
50 undertaken. The general public must be kept informed in a timely manner about any  
51 strike actions and the restrictions they may have on health care.<sup>13</sup>

## 1 ETHICAL ISSUE

2

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

11

## 12 REVIEW OF RELEVANT LITERATURE

13

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

19

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

28

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

40

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

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

16  
 17 Others have held that strikes by physicians are almost never justifiable.<sup>22-24</sup> Strikes by physicians  
 18 raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

19  
 20       Whatever justification they may have, strikes or “slow downs” by segments of the  
 21       profession have seriously damaged the image of medicine as a profession dedicated to  
 22       service above its own interests. One of the distinguishing features of the medical  
 23       profession has thus been compromised by physicians themselves. Those who choose to  
 24       pursue self-interest, as union members may, cannot at the same time demand a superior  
 25       moral position in society.<sup>22</sup>

26  
 27 Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle  
 28 that the duty to promote the good of the patient is always paramount, and that strikes will always  
 29 harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to  
 30 disrupt care, inconvenience, or possibly harm patients, even if minimally, in order to pressure  
 31 administrators into acceding to the demands of the striking physicians. Even granting that the  
 32 ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the  
 33 short run, and this conflicts with the profession’s ancient duty to protect patients from harm.

34  
 35 Moreover, opponents take issue with the consequentialist argument that some patients could  
 36 justifiably be exposed to potential harms now for the sure benefit of others in the future. They  
 37 argue that a primary principle of ethics is that persons should always be treated as ends in  
 38 themselves and never as means only. Physician strikes, by their nature, instrumentalize some  
 39 patients, using their potential harm as means of achieving physicians’ ends, even if those ends are  
 40 justifiable and good.

41  
 42 Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the  
 43 glue that holds the patient-physician relationship together. The sense that one’s own health as a  
 44 patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in  
 45 the profession.

46  
 47 While there is not a substantive body of empirical research on the effects of physician strikes on  
 48 patient outcomes, there are some data. Although the majority of available empirical evidence  
 49 shows that strikes have minimal impact on patient care,<sup>25-28</sup> much of the data are of relatively poor  
 50 quality, are at risk of bias, and suffer from a lack of generalizability.<sup>26,27</sup> Furthermore, most studies  
 51 examine patient mortality as the primary outcome of interest, which has limitations as an indicator

1 of deleterious change in patient health outcomes.<sup>25</sup> Importantly, a 2019 study found a slight  
2 increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the  
3 ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority  
4 groups more likely to experience worse care when hospital systems are under strain<sup>28</sup>. This  
5 observation has critical importance in determining care for vulnerable populations when  
6 considering collective actions. Additionally, there is a lack of crucial research on how collective  
7 actions by physicians impact patient perceptions of and trust in both the medical profession and  
8 health care institutions. Reports of strongly negative public perceptions during a recent physicians'  
9 strike in Korea, while not systematic, suggest a note of caution.<sup>29</sup>

## 10 ETHICAL ANALYSIS

11  
12  
13 In its review of [Opinion 1.2.10](#), "Political Action by Physicians," CEJA has examined the ethics of  
14 collective actions by physicians. While the practical issue for consideration is whether disruptive  
15 collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical  
16 dilemma is whether physicians can, in fact, fully understand themselves as professionals called to  
17 prioritize patient welfare over their own self-interest while engaging in tactics that have the  
18 potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be  
19 long-term patient benefit.

20  
21 Historically, physicians retained strong independence in clinical practice, and self-regulation  
22 permitted this professionalism to flourish. However, the growth of the health care sector has seen  
23 an increase in the complexity of health care systems, the transition to a majority physician  
24 employment structure, and as a result, a loss of physician independence and control in clinical  
25 practice. This bureaucratization has led physicians to seek other non-physicians to run the  
26 administrative aspects of their practices, and decreasing margins has led physicians to seek capital  
27 infusions and buyouts from private equity firms and venture capitalists, further driving the  
28 financialization of medicine and the employment of physicians.

29  
30 The result is a general loss of control over practice conditions that have driven dissatisfaction,  
31 burnout, and early retirement from the profession. However, the issue is not necessarily  
32 employment itself, but the associated loss of independence of clinical practice and control over the  
33 clinical environment, which many today see as the de-professionalization of medicine.

34  
35 For those seeking to maintain and restore physician authority and independence, the primary  
36 avenue has been to pursue legal and political actions, such as lobbying (either independently or  
37 through medical associations). However, with the change towards physician employment,  
38 physicians are now considering the use of tools that laborers have historically relied on for  
39 negotiating, such as legally permissible collective actions, in their attempts to improve patient care.  
40 This acceptance of the tools of organized labor, however, is in tension with medicine's self-  
41 understanding and public representation of itself as a profession with distinct privileges granted by  
42 society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms  
43 of collective action are not likely to violate the norms of medical professionalism<sup>30</sup>. Disruptive  
44 collective actions, however, which have the potential to disrupt the day-to-day workflow of  
45 physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the  
46 medical profession's fundamental duty to do no harm and care for patients. Any disruptive  
47 collective action that causes harm to patients is inherently inconsistent with the responsibilities and  
48 duties of physicians.

49  
50 Disruptive collective actions that create the potential for harm to patients, even minimally, and  
51 even if undertaken for the purpose of improving the care of other patients in the future, are

1 therefore to be avoided. This does not mean, however, that all forms of disruptive collective action  
2 must be avoided. Certain forms of disruptive action, such as collective refusal to comply with  
3 administrative directives that are understood as antithetical to good patient care or otherwise  
4 incompatible with the norms of professional ethics, may be ethically justified. Other forms of  
5 disruptive action that are aimed at disrupting administrative processes such as billing but do not  
6 disrupt service to patients, might also be justified. Disruptive actions should only be undertaken,  
7 however, as a last resort when good faith negotiations have broken down and the aim of the action  
8 is to improve patient care.

9  
10 CONCLUSION

11  
12 Physicians must uphold their central ethical and professional responsibilities to patients when  
13 considering collective actions. When considering disruptive collective actions, physicians should  
14 take into account that the care of current patients must be continued and not compromised; urgent,  
15 emergent and otherwise needed medical care must still be provided; and all other non-disruptive  
16 actions that do not negatively impact patients must first be exhausted. Additionally, the primary  
17 goal of the action must be to improve patient care and not solely physician self-interest. To protect  
18 the integrity of the profession, patients and the public should also be informed well in advance and  
19 be continuously updated with respect to the demands being made and the actions being undertaken,  
20 with the terms for resolving disruptive actions made public and open to scrutiny and discussion.  
21 Whether all these conditions can ever be met in a physician strike or work slowdown remains an  
22 open question.

23  
24 Physicians thinking about participating in disruptive collective actions therefore must first consider  
25 their professional responsibilities and obligations.

26  
27 RECOMMENDATIONS

28  
29 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the  
30 remainder of the report be filed:

- 31  
32 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:

33  
34 Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

35  
36 Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the  
37 public arena, and within their institutions. Indeed, physicians have an ethical responsibility to  
38 seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to  
39 the best interests of patients. However, advocacy actions should not put the wellbeing of  
40 patients in jeopardy.

41  
42 Collective action is one means by which physicians can advocate for patients, the health of  
43 communities, the profession, and their own health. Physicians have a responsibility to avoid  
44 disruption to patient care when engaging in any collective action. When considering collective  
45 actions that have the potential to be disruptive, whether aimed at changing the policies of  
46 government, the private sector, or their own institutions, there are additional considerations that  
47 should be addressed. These include avoiding harm to patients, minimizing the impact of actions  
48 on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the  
49 responsibility to improve patient care, avoiding mental and physical harms to physicians.

1 promoting physician wellbeing, upholding the values and integrity of the profession, and  
2 considering alternative measures that could reasonably be expected to achieve similar results  
3 with less potential effect on patient and physician wellbeing.  
4

5 When considering participation ~~Physicians who participate~~ in advocacy activities, including  
6 collective actions:  
7

8 (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not~~  
9 ~~compromised.~~ Physicians should recognize that, in pursuing their primary commitment to  
10 patients, physicians can, and at times may have an obligation to, engage in collective  
11 political action to advocate for changes in law and institutional policy aimed at promoting  
12 patient care and wellbeing.  
13

14 (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may~~  
15 ~~reduce access to care, eliminate or delay needed care, and interfere with continuity of care~~  
16 ~~and should not be used as a bargaining tactic. In rare circumstances, briefly limiting~~  
17 ~~personal availability may be appropriate as a means of calling attention to the need for~~  
18 ~~changes in patient care. Physicians should be aware that some actions may put them or~~  
19 ~~their organizations at risk of violating antitrust laws or laws pertaining to medical licensure~~  
20 ~~or malpractice.~~ Physicians may also engage in collective action to advocate for changes  
21 within their institutions, including changes in patient care practices, physician work  
22 conditions, health and wellbeing, and/or institutional culture that negatively affect patient  
23 care.  
24

25 (i) Physicians should refrain from collective action that would likely jeopardize the health  
26 of patients or compromise patient care.  
27

28 (ii) Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of  
29 collective action that do not compromise patient care, with the primary objective to  
30 improve patient care and outcomes by calling attention to and/or making needed  
31 changes in practices, protocols, incentives, expectations, structures, and/or institutional  
32 culture.  
33

34 (iii) Physicians should avoid disruptive collective actions that could directly compromise  
35 patient care, including strikes, due to their potential to undermine physicians' primary  
36 duty to patient welfare, and should not use such actions primarily for physician self-  
37 interest.  
38

39 (c) Physicians should avoid forming workplace or other alliances, such as unions, with  
40 ~~workers~~ colleagues and others who do not share physicians' primary and overriding  
41 commitment to patients.  
42

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

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

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 05-A-26

Subject: CEJA’s Sunset Review of 2016 House Policies

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

- 5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A  
7 policy will typically sunset after ten years unless action is taken by the House of Delegates  
8 to retain it. Any action of our AMA House that reaffirms or amends an existing policy  
9 position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for  
10 another 10 years.  
11
  - 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of  
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies  
15 shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that  
16 has been asked to review policies shall develop and submit a report to the House of  
17 Delegates identifying policies that are scheduled to sunset; (d) For each policy under  
18 review, the reviewing council can recommend one of the following actions: (i) retain the  
19 policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with  
20 more recent and like policy; (e) For each recommendation that it makes to retain a policy in  
21 any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The  
22 Speakers shall determine the best way for the House of Delegates to handle the sunset  
23 reports.  
24
  - 25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy  
26 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more  
27 current policy, or has been accomplished.  
28
  - 29 4. The AMA councils and the House of Delegates should conform to the following guidelines  
30 for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or  
31 directive has been accomplished; or (c) when the policy or directive is part of an  
32 established AMA practice that is transparent to the House and codified elsewhere such as  
33 the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies  
34 and Practices.

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

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

2

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

4

5 RECOMMENDATION

6

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

Fiscal Note: Minimal

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
<a href="#">D-370.985</a>	Organ Donation	Our AMA will study potential models for increasing the United States organ donor pool.	Retain; remains relevant.
<a href="#">G-600.130</a>	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.
<a href="#">H-140.840</a>	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 <u>AMA Ethical Opinion E-5.045</u> the <u>AMA Code of Medical Ethics Opinions 3.1.3 and 3.1.4</u> , for publication of any material related to the treatment of a patient

<p><a href="#">H-140.966</a></p>	<p>Decisions Near the End of Life</p>	<p>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.</p> <p>(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.</p> <p>(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.</p> <p>(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.</p> <p>(5) Our AMA supports continued research into and education concerning pain management.</p>	<p>Retains; remains relevant.</p>
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<a href="#">H-160.999</a>	<p>Statements on the Medical Profession</p>	<p>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.</p>	<p>Retain; remains relevant.</p>
<a href="#">H-175.993</a>	<p>Fraudulent Health Practices</p>	<p>The AMA favors providing information and educational materials to the public and the profession on fraudulent health practices.</p>	<p>Retain; remains relevant.</p>
<a href="#">H-230.966</a>	<p>Physician Appeals Mechanism for Denial of Academic Appointment</p>	<p>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.</p>	<p>Retain; remains relevant.</p>
<a href="#">H-270.960</a>	<p>Inappropriate Legislative Mandates of eGFR Calculations</p>	<p>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.</p>	<p>Retain; remains relevant.</p>

<p><a href="#">H-275.990</a></p>	<p>Clinical Diagnostic Electromyography</p>	<p>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.</p> <p>2 Non-physician health care professionals should not expand their scope of practice to include performing needle electromyography.</p> <p>3. Physicians should not prepare reports and submit claims on needle electromyographic studies that they did not perform or personally supervise.</p> <p>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.</p>	<p>Retain; remains relevant.</p>
<p><a href="#">H-370.964</a></p>	<p>Surrogate Consent for Living Organ Donation</p>	<p>Our AMA opposes the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.</p>	<p>Retain; remains relevant.</p>
<p><a href="#">H-450.928</a></p>	<p>Physician Decision Making</p>	<p>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.</p>	<p>Retain; remains relevant.</p>
<p><a href="#">H-450.990</a></p>	<p>Physician Information for Credentialing</p>	<p>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) believes that legal immunity for submitting or sharing truthful and accurate information on quality care should be provided to physicians by appropriate legislation.</p>	<p>Retain; remains relevant.</p>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(A-26)

Introduced by: American College of Medical Genetics and Genomics, Medical Student  
Section

Subject: Ethical Guidance on Postmortem Sample Collection for Genetic Testing

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, postmortem genetic testing (PMGT), or molecular autopsy, of blood and/or fresh  
2 tissue is an increasingly recognized tool for identifying genetic causes in cases of sudden  
3 unexplained death<sup>1,2,7,14</sup>; and  
4

5 Whereas, PMGT is clinically useful in identifying pathogenic variants and determining familial  
6 risk for conditions such as thoracic aortic aneurysm and dissection, inherited arrhythmogenic  
7 syndromes (such as cardiomyopathies and channelopathies), and sudden infant death  
8 syndrome or sudden unexplained death in childhood<sup>2,12,13</sup>; and  
9

10 Whereas, PMGT allows for targeted cascade testing of relatives to identify potential carriers,  
11 implement preventative measures and surveillance (such as lifestyle modifications and regular  
12 imaging), and provide families with psychological benefits and closure following sudden  
13 unexplained death<sup>1,3-6</sup>; and  
14

15 Whereas, leading specialty societies including the American College of Medical Genetics and  
16 Genomics, the Asia Pacific Heart Rhythm Society, Heart Rhythm Society, European Heart  
17 Rhythm Society, Latin American Heart Rhythm Society, the American Heart Association, and  
18 the National Association of Medical Examiners, recommend postmortem collection and storage  
19 of blood and/or tissue for PMGT in cases of sudden unexplained death, however more guidance  
20 on informed consent, privacy, and storage would be helpful for healthcare professionals,  
21 patients, and families<sup>4,7,8,9,11,15,16</sup>; and  
22

23 Whereas, our American Medical Association (AMA) Code of Ethics has established Opinion  
24 4.1.1 (“Genetic Testing & Counseling”), Opinion 3.2.2 (“Confidentiality Postmortem”), and  
25 Opinion 4.1.4 (“Forensic Genetics”), which collectively emphasize physicians’ ethical  
26 responsibilities to protect the genetic information of patients and their biological relatives while  
27 utilizing genetic testing to help diagnose and predict future health risks, but there is no clear  
28 statement on the ethics of collecting, storing, and sharing genetic information after death<sup>10</sup>;  
29 therefore be it  
30

31 RESOLVED, that our American Medical Association study the ethical responsibility of  
32 physicians in the collection and storage of postmortem biological samples for genetic testing  
33 and research when clinically indicated and aligned with existing specialty guidelines. (Directive  
34 to Take Action)  
35

Fiscal Note: Minimal – less than \$5,000

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## RELEVANT AMA POLICY

### 4.1.1 Genetic Testing & Counseling

Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others.

Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient's care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological implications for the individual's biological relatives; (iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and (iv) that the physician will be available to assist in

communicating with relatives. (d) Obtain the individual's informed consent for the specific test or tests to be performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information. [Issued: 2016]

#### **H-480.944 Improving Genetic Testing and Counseling Services**

Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. [Res. 913, I-16]

#### **H-185.919 Payment and Coverage for Genetic/Genomic Precision Medicine**

Our AMA encourages public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: (a) Promote transparency and clarity; (b) Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies; (c) Describe the evidence being considered and methods for updating the evidence; (d) Provide opportunities for comment and review as well as meaningful reconsiderations; and (e) Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival. Our AMA encourages coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage. Our AMA will work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact. Our AMA encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services. Our AMA supports continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine. [Joint CMS / CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 06, A-18 Reaffirmed: CMS Rep. 06, A-19]

#### **H-85.954 Importance of Autopsies**

Our AMA: (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: CCB/CLRPD Rep. 01, A-24]

#### **4.1.2 Genetic Testing for Reproductive Decision Making**

Genetic testing can provide information to help prospective parents make informed decisions about childbearing. Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse ancestries becomes more common and tests for more conditions become more accurate and less costly, the relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians may ethically provide genetic testing to inform reproductive decision making when the patient requests, but may also wish to offer broad screening to all persons who are considering having a child. Physicians who provide reproductive health care that includes genetic testing should: (c) Obtain the individual's informed consent to the specific test or tests to be performed. Physicians should ascertain whether the person wishes to be informed about incidental findings. (d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors relevant to a decision about childbearing. (e) Respect an

individual's decision to terminate or continue a pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. [Issued 2016]

**D-460.996 Medical Genetics**

Our AMA will join with the American College of Medical Genetics and other professional and lay organizations to: (1) Publicize the resources and services offered by medical genetics professionals to other medical specialties; and (2) advocate for federal funding specifically targeted to the development and stable support of a clinical genetics infrastructure commensurate with the application of new genetic knowledge to the prevention and treatment of human disease. [Res. 527, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002  
(A-26)

Introduced by: Florida, the American Academy of Emergency Medicine

Subject: Physician Workload and Scheduling

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, excessive patient volumes and overly demanding scheduling requirements can  
2 undermine patient safety, contribute to clinician burnout, and increase the risk of medical errors,  
3 with evidence demonstrating a significant association between physician burnout and self-  
4 reported medical errors<sup>1</sup>; and

5  
6 Whereas, high workload, time pressure, and inefficient practice environments are well-  
7 established drivers of physician burnout and are associated with decreased quality of care and  
8 adverse patient outcomes<sup>2,3,4</sup>; and

9  
10 Whereas, physicians face substantial cumulative workload beyond direct patient care, including  
11 documentation and administrative tasks, which further compress time available for safe and  
12 thorough patient care<sup>5,6</sup>; and

13  
14 Whereas, workload, fatigue, and time pressure are recognized contributors to medical error and  
15 patient safety events<sup>7</sup>; and

16  
17 Whereas, our AMA Code of Medical Ethics Opinion 1.1.6, *Quality*, affirms that physicians have  
18 an ethical obligation to provide safe, effective, and high-quality care, which may be  
19 compromised under conditions of excessive workload; and

20  
21 Whereas, our AMA Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships*,  
22 requires physicians to place patient welfare above external influences, including administrative  
23 or financial pressures that may drive unsafe scheduling practices; and

24  
25 Whereas, our AMA Code of Medical Ethics Opinion 9.3.1, *Physician Health and Wellness*,  
26 states that when physician health or wellness is compromised, the safety and effectiveness of  
27 patient care may also be compromised; and

28  
29 Whereas, our AMA's policy and advocacy efforts on physician well-being support reducing  
30 system-level drivers of burnout and promoting flexibility and autonomy in practice conditions;  
31 therefore be it

32  
33 RESOLVED, that our American Medical Association adopt policy affirming that physicians have  
34 the professional right and authority to decline, modify, or limit patient volume expectations,  
35 scheduling mandates, and staffing conditions that compromise patient safety or their ability to  
36 provide safe, thorough, and patient-centered care (New HOD Policy); and be it further

37  
38 RESOLVED, that our AMA advocate for and support state and federal legislation or regulation  
39 that ensures local practicing physicians direct and control the development and implementation

- 1 of patient scheduling protocols, workload standards, patient panel limits, and clinical staffing
- 2 models within their practices and health systems, based on clinical complexity, time required for
- 3 direct and indirect care, and safe practice standards rather than productivity or revenue targets.  
(Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/9/26

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#### RELEVANT AMA POLICY

##### **AMA Code of Medical Ethics Opinion 1.1.6 – Quality**

As 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.

While responsibility for quality of care does not rest solely with physicians, their role is essential.

Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- a. Keeping current with best care practices and maintaining professional competence.
- b. Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- c. Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.
- d. Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
- e. Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
- f. Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

##### **AMA Code of Medical Ethics Opinion 1.1.1 – Patient-Physician Relationships**

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

**AMA Code of Medical Ethics Opinion 9.3.1, Physician Health and Wellness**

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(A-26)

Introduced by: American Academy of Ophthalmology

Subject: Artificial Intelligence to Bolster Physician-Led Team-Based Care

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, a randomized quality improvement study found that large language model-generated  
2 plain language summaries of ophthalmologist encounter notes improved comprehension and  
3 clarity for non-ophthalmology clinicians, enhancing interdisciplinary communication; and  
4

5 Whereas, a cohort study demonstrated that an artificial intelligence deterioration model-enabled  
6 intervention, when paired with a collaborative nurse-physician workflow, was associated with an  
7 absolute reduction in escalations of care, including rapid response activation, ICU transfer, or  
8 cardiopulmonary arrest; and  
9

10 Whereas, a study of artificial intelligence-enabled collaborative team workflows—one for  
11 advance care planning and the other for reducing unplanned escalations of care—found that  
12 these workflows reduced misalignment of risk perception and increased coordination between  
13 physicians and non-physician team members in performing needed clinical interventions; and  
14

15 Whereas, physicians are uniquely qualified to lead coordinated care teams, which is the best  
16 way to support high-quality care and lower costs; and  
17

18 Whereas, artificial intelligence is an emerging tool to reinforce the effectiveness of physician-led  
19 teams by enhancing collaboration with non-physician clinicians, improving communication, and  
20 aligning care around physician judgment; therefore be it  
21

22 RESOLVED, that our American Medical Association make efforts to educate physicians on  
23 evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-  
24 physician clinicians through improved interdisciplinary communication, decision support, and  
25 workflow integration (Directive to Take Action); and be it further  
26

27 RESOLVED, that our AMA support the development and dissemination of best practices for AI  
28 integration into physician-led care teams, with emphasis on safety monitoring, transparency,  
29 cyber hygiene, and preserving physician leadership in clinical decision-making (New HOD  
30 Policy); and be it further  
31

32 RESOLVED, that our AMA encourage further research on AI interventions that demonstrate  
33 how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk  
34 perception, and improve coordination of care. (New HOD Policy)  
35

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 4/14/26

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## RELEVANT AMA POLICY

### **D-480.952 Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence**

Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings.

1. Our AMA advocates that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:
  - a. establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
  - b. implement relevant security measures and privacy protections;
  - c. provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and
  - d. implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts. [Res. 507, A-25]

### **D-480.954 Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms**

1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
  - a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
  - b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
  - c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
  - d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
2. Our AMA will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight. [CSAPH Rep. 08, A-25]

### **H-310.898 Increasing Education on Physician-Led Care and Advocacy in Residency Training**

Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.

Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations. [Res. 309, A-25]

**G-615.998 Creation of an AMA Council with a Focus on Digital Health Technologies and AI**

Our American Medical Association will establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition this task force to a new council and report back A-25 on this transition.

Our AMA Task Force on AI, Digital Health, and Informatics will work toward an informed recommendation on the long-term model for HOD input with a report back at the 2026 Interim meeting. [Res. 606, A-24; Appended: BOT Rep. 24-25]

**H-160.912 The Structure and Function of Interprofessional Health Care Teams**

Our American Medical Association defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.

1. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that they are trained to perform.
2. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
3. Our AMA adopts the following principles to guide physician leaders of health care teams:
  - a. focus the team on patient and family-centered care.
  - b. make clear the team's mission, vision and values.
  - c. direct and/or engage in collaboration with team members on patient care.
  - d. be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
  - e. foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
  - f. encourage adherence to best practice protocols that team members are expected to follow.
  - g. manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
  - h. promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
  - i. support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
  - j. facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
  - k. review measures of 'population health' periodically when the team is responsible for the care of a defined group.
4. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
5. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members. [Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, 1-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17; Reaffirmed: CMS Rep. 1, 1-23; Modified: Speakers Rep. 02, I-24]

**H-295.857 Augmented Intelligence in Medical Education**

Our AMA encourages:

- (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
- (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
- (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
- (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new

training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

(10) close collaboration with and oversight by practicing physicians in the development of AI applications. [BOT Rep.41, A-18; Reaffirmed: CMS Rep.97, A-24; Reaffirmed: CSAPH Rep. 08, A-25]

### **H-390.843 Physician-Led, Single and Multi-Specialty, Organized Group Practice Models**

1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care.

2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost. [Sub. Res. 212, I-13; Appended: BOT Rep. 21, A-15; Reaffirmed: CMS Rep. 01, A-25]

### **H-480.940 Augmented Intelligence in Health Care**

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

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;

b. is transparent;

c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and

e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

5. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

6. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. [BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25]

### **H-480-931 Augmented Intelligence Development, Deployment, and Use in Health Care**

1. General Governance

a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.

b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance

policies should include interdepartmental and interagency collaboration.

- c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
- e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
- g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
- h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
- i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

## 2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care

- a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
  - i. AI disclosure should align and meet ethical standards or norms.
  - ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
  - iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
  - iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
- c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
- d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

## 3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

- a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

- i. Regulatory approval status.
- ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
- iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
- iv. Intended population and intended practice setting.
- v. Clear description of any limitations or risks for use, including possible disparate impact.
- vi. Description of how impacted populations were engaged during the AI lifecycle.
- vii. Detailed information regarding data used to train the model:
  1. Data provenance.
  2. Data size and completeness.
  3. Data timeframes.
  4. Data diversity.
  5. Data labeling accuracy.
- viii. Validation Data/Information and evidence of:
  1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
  2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
  3. Algorithmic validation.
  4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
  5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
  6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
  7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
- ix. Data Use Policy:
  1. Privacy.
  2. Security.
  3. Special considerations for protected populations or groups put at increased risk.
- x. information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
- xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
- b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]
4. Generative Augmented Intelligence
  - a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
  - b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
    - ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
    - iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
    - iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
    - v. Data privacy.
    - vi. Cybersecurity.
    - vii. Physician liability associated with the use of generative AI tools.
  - c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at

(3)(d)]

d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

#### 5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]

i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

#### 6. Data Privacy and Augmented Intelligence

##### a. Entity Responsibility:

i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

##### b. User Education:

i. Users should be provided with training specifically on generative AI. Education should address:

1. Legal, ethical, and equity considerations.

2. Risks such as data breaches and re-identification.

3. Potential pitfalls of inputting sensitive and personal data.

4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

#### 7. Augmented Intelligence Cybersecurity

a. AI systems must have strong protections against input manipulation and malicious attacks.

b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.

c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.

d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies

- a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
- b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
- c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
- d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
- e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
- f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be

monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws. [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep.08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(A-26)

Introduced by: Women Physicians Section

Subject: Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities

Referred to: Reference Committee on Ethics and Bylaws

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- 1 Whereas, individuals with intellectual and developmental disabilities (IDD) represent a diverse  
2 population with varying levels of decision-making capacity, and many retain meaningful ability to  
3 participate in reproductive healthcare decisions;<sup>1-3</sup> and  
4
- 5 Whereas, decision-making capacity is task-specific, meaning individuals with IDD may have the  
6 ability to provide informed consent for certain reproductive decisions even if they require support  
7 or guardianship for other aspects of daily living;<sup>4-6</sup> and  
8
- 9 Whereas, supported decision-making frameworks enable individuals with IDD to make their own  
10 healthcare choices with assistance in understanding information, communicating preferences,  
11 and evaluating options, without transferring decision-making authority;<sup>4-6</sup> and  
12
- 13 Whereas, historical abuses—including forced sterilization and coercive contraception—have  
14 disproportionately targeted people with disabilities, particularly women, people of color, and  
15 LGBTQ+ individuals, resulting in long-standing mistrust and ongoing reproductive injustice;<sup>7-10</sup>  
16 and  
17
- 18 Whereas, national clinical organizations, including the American College of Obstetricians and  
19 Gynecologists, have identified patients with disabilities as a population facing persistent and  
20 significant barriers to reproductive healthcare—including inaccessible clinical environments,  
21 communication challenges, and legal complexities surrounding permanent contraception—and  
22 have issued dedicated guidance to address these inequities, underscoring the urgency of  
23 strengthening protections for autonomy and valid consent for individuals with intellectual and  
24 developmental disabilities;<sup>11</sup> and  
25
- 26 Whereas, forced sterilization of people with disabilities remains legally permissible in 31 states,  
27 as acknowledged in recent federal resolutions, and several states have recently debated  
28 legislation either restricting or expanding guardians' authority to consent to sterilization or  
29 long-acting contraception on behalf of individuals with IDD, including New York Senate Bill  
30 S3357 (2025–2026);<sup>10, 15-17</sup> and  
31
- 32 Whereas, multiple states have recently enacted or introduced supported decision-making (SDM)  
33 laws that recognize the right of people with disabilities to make their own healthcare decisions  
34 with assistance, with at least 39 states and the District of Columbia adopting SDM statutes or  
35 court-recognized frameworks;<sup>4-6, 18</sup> and

1 Whereas, ethical contraceptive care requires maximizing patient agency, providing accessible  
2 communication, and avoiding paternalistic or convenience-based decision-making by caregivers  
3 or clinicians;<sup>4-6, 12-14</sup> therefore be it  
4

5 RESOLVED, that our American Medical Association affirm that individuals with intellectual and  
6 developmental disabilities (IDD) have the right to meaningful participation in all reproductive  
7 healthcare decisions to the maximum extent of their abilities (New HOD Policy); and be it further  
8

9 RESOLVED, that our AMA amend H-90.968 “Medical Care of Persons with Disabilities” by  
10 addition to read as follows:

11 1. Our American Medical Association encourages:

- 12 a. clinicians to learn and appreciate variable presentations of complex functioning  
13 profiles in all persons with disabilities including but not limited to physical,  
14 sensory, developmental, intellectual, learning, and psychiatric disabilities and  
15 chronic illnesses.
- 16 b. medical schools and graduate medical education programs to acknowledge the  
17 benefits of education on how aspects in the social model of disability (e.g.  
18 ableism) can impact the physical and mental health of persons with disabilities.
- 19 c. medical schools and graduate medical education programs to acknowledge the  
20 benefits of teaching about the nuances of uneven skill sets, often found in the  
21 functioning profiles of persons with developmental disabilities, to improve quality  
22 in clinical care.
- 23 d. education of physicians on how to provide and/or advocate for developmentally  
24 appropriate and accessible medical, social and living support for  
25 patients with disabilities so as to improve health outcomes.
- 26 e. medical schools and residency programs to encourage faculty and trainees to  
27 appreciate the opportunities for exploring diagnostic and therapeutic challenges  
28 while also accruing significant personal rewards when  
29 delivering care with professionalism to persons with profound disabilities and  
30 multiple co-morbid medical conditions in any setting.
- 31 f. medical schools and graduate medical education programs to establish and  
32 encourage enrollment in elective rotations for medical students and residents at  
33 health care facilities specializing in care for the disabled.
- 34 g. cooperation among physicians, health & human services professionals, and a  
35 wide variety of adults with disabilities to implement priorities and quality  
36 improvements for the care of persons with disabilities.

37 2. Our AMA seeks:

- 38 a. legislation to increase the funds available for training physicians in  
39 the care of individuals with disabilities, and to increase the reimbursement for the  
40 health care of these individuals.
- 41 b. insurance industry and government reimbursement that reflects the true  
42 cost of health care of individuals with disabilities.

43 3. Our AMA entreats health care professionals, parents, and others participating in  
44 decision-making to be guided by the following principles:

- 45 a. All people with disabilities, regardless of the degree of their disability, should  
46 have access to appropriate and affordable medical and dental care throughout  
47 their lives.
- 48 b. An individual’s medical condition and welfare must be the  
49 basis of any medical decision. Our AMA advocates for the highest  
50 quality medical care for persons with profound disabilities; encourages support  
51 for health care facilities whose primary mission is to meet the  
52 health care needs of persons with profound disabilities; and informs physicians  
53 that when they are presented with an opportunity to care for  
54 patients with profound disabilities, that there are resources available to them.

- 1 4. Our AMA will collaborate with appropriate stakeholders to create a model general  
 2 curriculum/objective that  
 3 a. incorporates critical disability studies.  
 4 b. includes people with disabilities as patient instructors in formal training sessions  
 5 and preclinical and clinical instruction.  
 6 5. Our AMA recognizes the importance of managing the health of children and  
 7 adults with developmental and intellectual disabilities as a part of overall patient care for  
 8 the entire community.  
 9 6. Our AMA supports efforts to educate physicians on health management of children and  
 10 adults with intellectual and developmental disabilities, as well as the  
 11 consequences of poor health management on mental and physical health for  
 12 people with intellectual and developmental disabilities.  
 13 7. Our AMA encourages the Liaison Committee on Medical Education,  
 14 Commission of Osteopathic College Accreditation, and allopathic and  
 15 osteopathic medical schools to develop and implement a curriculum on the care and  
 16 treatment of people with a range of disabilities.  
 17 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and  
 18 graduate medical education programs to develop and implement curriculum on providing  
 19 appropriate and comprehensive health care to people with a range of disabilities.  
 20 9. Our AMA encourages the Accreditation Council for Continuing Medical Education,  
 21 specialty boards, and other continuing medical education providers to develop and  
 22 implement continuing programs that focus on the care and treatment of people with a  
 23 range of disabilities.  
 24 10. Our AMA will advocate that the Health Resources and Services Administration  
 25 include persons with disabilities as a medically underserved population.  
 26 11. Specific to people with developmental and intellectual disabilities, a uniquely  
 27 underserved population, our AMA encourages:  
 28 a. Medical schools and graduate medical education programs to acknowledge the  
 29 benefits of teaching about the nuances of uneven skill sets, often found in the  
 30 functioning profiles of persons with developmental and intellectual disabilities, to  
 31 improve quality in clinical education.  
 32 b. Medical schools and graduate medical education programs to establish and  
 33 encourage enrollment in elective rotations for medical students and residents at  
 34 health care facilities specializing in care for individuals with developmental and  
 35 intellectual disabilities.  
 36 c. Cooperation among physicians, health and human services professionals, and a  
 37 wide variety of adults with intellectual and developmental disabilities to  
 38 implement priorities and quality improvements for  
 39 the care of persons with intellectual and developmental disabilities.  
 40 d. Clinicians to obtain direct, task-specific informed consent from individuals with  
 41 IDD whenever they demonstrate capacity for the decision at hand and, when  
 42 legally required, the consent of a guardian or other authorized decision-maker.

43 (Modify Current HOD Policy); and be it further  
 44

45 RESOLVED, that our AMA support clinician education on disability-competent reproductive  
 46 care, including accessible communication strategies, historical context, and best practices for  
 47 ethical contraceptive counseling for individuals with IDD. (New HOD Policy)  
 48

Fiscal Note: Minimal – less than \$5,000

Received: 4/15/26

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16. U.S. House of Representatives. H.Res.453 (2024): Disability Reproductive Equity Day Resolution.
17. U.S. Senate. S. Res. 703 (2024): Acknowledging ongoing legality of forced sterilization in 31 states and D.C.
18. Supported Decision-Making State Laws and Court Decisions. [SupportedDecision.org](https://SupportedDecision.org). Accessed February 2026

## RELEVANT AMA POLICY

### H-90.96 Medical Care of Persons with Disabilities

1. Our American Medical Association encourages:
  - a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.
  - b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.
  - c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.
  - d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
  - e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.
  - f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
  - g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks:
  - a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.

- b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:
  - a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.
  - b. An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.
4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that
  - a. incorporates critical disability studies.
  - b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:
  - a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.
  - b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.
  - c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

[CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1<sup>st</sup> Resolved: Res. 304, A-18; Modified: Res. 428, A-22]

#### **H-90.967 Support for Persons with Intellectual Disabilities**

Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

[Res. 01, A-16]

#### **H-65.965 Support of Human Rights and Freedom**

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.
4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

[CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22; Modified: Speaker Rep. 02, I-24]

#### **D-330.900 Support for Medicare Coverage of Contraceptive Methods**

Our AMA will work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved contraceptive methods for contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of eligibility pathway (age or disability).

[Res. 117, A-19]

#### **H-510.984 Infertility Benefits for Veterans**

1. Our American Medical Association supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
6. Our AMA will work with interested organizations to encourage TRICARE to cover:
  1. Fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE.
  2. Gamete preservation for active-duty military personnel and activated reservist military personnel.
7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of service-connected disability, marital status, gender or sexual orientation.

[CMS Rep. 01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22; Appended: Res. 801, I-22; Reaffirmed: Res. 005, I-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005  
(A-26)

Introduced by: Indiana

Subject: Impersonation of a Physician

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, the impersonation of a licensed physician poses a serious threat to public health and  
2 patient safety, leading to potential misdiagnoses, improper treatments, and fraudulent medical  
3 practices; and  
4

5 Whereas, there have been documented cases nationwide of individuals fraudulently  
6 representing themselves as physicians, leading to physical, emotional, and financial harm to  
7 patients; and  
8

9 Whereas, organizations in our state offering care to pregnant people often are mistaken as  
10 medical facilities staffed by medical providers; and  
11

12 Whereas, the unauthorized practice of medicine undermines the integrity of the medical  
13 profession and erodes public trust in legitimate healthcare providers; and  
14

15 Whereas, Indiana Code § 35-44.1-2-6 currently addresses impersonation of public servants, but  
16 does not explicitly include licensed physicians within its scope unless they are acting in a  
17 governmental capacity; and  
18

19 Whereas, Indiana Code § 25-22.5-8.2 currently makes it a felony to unlawfully practice medicine  
20 or osteopathic medicine; and  
21

22 Whereas, existing state and federal penalties for impersonating a physician may not adequately  
23 deter such fraudulent behavior, and stronger legal repercussions are necessary to prevent and  
24 penalize such offenses; and  
25

26 Whereas, many states have enacted strict laws to address medical impersonation, and Indiana  
27 should align its policies with the most stringent protections for public safety; therefore be it  
28

29 RESOLVED, that our American Medical Association recognizes physician impersonation as a  
30 significant threat to public health and patient safety; supports the creation and enforcement of  
31 state laws prohibiting such conduct; encourages clear public reporting mechanisms through  
32 state medical boards; and promotes improved coordination among regulatory bodies to prevent  
33 and address impersonation of licensed physicians. (New HOD Policy)  
34

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006  
(A-26)

Introduced by: Indiana

Subject: Investigating Moral Injury Related to Organ Procurement Practices

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, Indiana is primarily served by the Indiana Donor Network, an organ procurement  
2 organization (OPO) designated as Tier 3 by the Centers for Medicare and Medicaid Services  
3 (CMS) in 2023, reflecting performance below national benchmarks for organ recovery and  
4 utilization<sup>1</sup>; and

5  
6 Whereas, Indiana physicians have raised concerns regarding OPO conduct, including  
7 aggressive donation approaches, inappropriate timing of family interactions, and lapses in  
8 transparency; practices that may compromise the therapeutic alliance with patients and families  
9 at the end of life; and

10  
11 Whereas, significant incidents have further eroded physician confidence in the OPO system,  
12 including a 2016 probation by the Organ Procurement and Transplantation Network (OPTN) for  
13 documentation and quality deficiencies<sup>2</sup>, a 2020 incident involving the accidental disposal of two  
14 viable kidneys<sup>3</sup>, and a 2024 investigative report revealing misuse of OPO-owned aircraft for  
15 non-clinical travel<sup>4</sup>; and

16  
17 Whereas, physicians in Indiana have experienced ethical distress and professional conflict  
18 during organ procurement, including inappropriate pressure to withdraw care to align with  
19 transplant timelines and the need to manage family trauma resulting from OPO missteps. These  
20 circumstances result in emotional strain and professional dissonance consistent with the clinical  
21 definition of moral injury; and

22  
23 Whereas, moral injury, distinct from burnout, is defined as psychological harm resulting from  
24 being forced to act against one's ethical or professional values<sup>5, 6</sup>; and

25  
26 Whereas, current American Medical Association (AMA) policy does not address physician moral  
27 injury arising from organ procurement practices, nor are there standardized institutional  
28 mechanisms for recognizing or addressing these harms<sup>7</sup>; therefore be it

29  
30 RESOLVED, that our American Medical Association study the national scope and causes of  
31 physician moral injury related to organ procurement, and to develop ethical guidelines and best  
32 practices that prioritize patient dignity and physician integrity in organ procurement practices.  
33 (Directive to Take Action)

34  
Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/15/26

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## RELEVANT AMA POLICY

### **Ethical Procurement of Organs for Transplantation H-370.967**

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. [BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18]

### **Endorsement of the Uniform Anatomical Gift Act (2006) H-370.968**

Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA. [BOT Action in response to referred for decision Res. 901, I-06; Reaffirmed: BOT Rep. 06, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007  
(A-26)

Introduced by: Indiana

Subject: Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software

Referred to: Reference Committee on Ethics and Bylaws

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- 1 Whereas, artificial intelligence (AI)-based scribe software is rapidly being integrated into clinical  
2 workflows with the goal of enhancing documentation efficiency and reducing physician  
3 administrative burden; and  
4  
5 Whereas, such technologies often rely on real-time or asynchronous data capture, which may  
6 include sensitive conversations between physicians and patients and raise concerns about the  
7 privacy of both parties; and  
8  
9 Whereas, current regulatory frameworks, including HIPAA, may not be sufficient enough to  
10 cover the legality of third-party AI scribe systems; and  
11  
12 Whereas, the storage, processing, and transmission of physician speech data by AI vendors  
13 may lack sufficient transparency, oversight, and limits on duration and secondary use, posing  
14 potential risks to personal and professional autonomy, workplace surveillance, and unauthorized  
15 profiling; and  
16  
17 Whereas, Indiana physicians have the right to practice in an environment that protects their  
18 privacy and ensures informed consent regarding the collection and usage of their data by AI  
19 systems; and  
20  
21 Whereas, the Indiana State Medical Association (ISMA) supports responsible innovation in  
22 medical technology that aligns with the ethical principles of autonomy, transparency, data  
23 minimization, and accountability; therefore be it  
24  
25 RESOLVED, that our American Medical Association pursue federal regulation of artificial  
26 intelligence (AI) scribe technologies that protects clinician and patient privacy by mandating  
27 informed consent, opt-in for secondary use, data minimization, and federal vendor  
28 accountability. (Directive to Take Action)  
29

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/15/26

## REFERENCES

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## RELEVANT AMA POLICY

### **Study of Minimum Competencies and Scope of Medical Scribe Utilization D-478.967**

Our American Medical Association will monitor the medical scribe industry periodically to identify important trends and will continue to review and promote strategies that help improve physician practice workflow. [BOT Rep. 20, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008  
(A-26)

Introduced by: Senior Physicians Section  
Subject: Senior Physicians Improving Patient Access  
Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, the SPS Governing Council seeks to advance initiatives that benefit patients,  
2 practicing physicians, and semi-retired or retired physicians alike; and  
3  
4 Whereas, the U.S. healthcare system faces persistent challenges, including physician workforce  
5 shortages that increase workloads and affect care delivery; and  
6  
7 Whereas, patients as well are experiencing excessive wait times for new physician  
8 appointments, and for obtaining expedited clinic visits for recently discharged patients; and  
9  
10 Whereas, many communities across the nation include a substantial number of semi-retired and  
11 retired physicians who can offer valuable expertise, experience and flexibility; and  
12  
13 Whereas, these seasoned physicians are well-positioned to provide initial consultations, to help  
14 ensure necessary previsit laboratory testing before patients see their primary physician, and  
15 help to facilitate prompt follow-up visits after recently hospital discharges through in-person or  
16 telehealth visits; and  
17  
18 Whereas, in some communities, programs exist that enable timely follow-up after hospital  
19 discharge, and some that introduce a patient to a new practice before seeing a new primary  
20 care physician, by involving late-career physicians (both semi-retired and retired)<sup>1,2</sup>; therefore  
21 be it  
22  
23 RESOLVED, that our American Medical Association look for innovative approaches to help  
24 alleviate the workload of actively practicing physicians while at the same time providing late-  
25 career physicians with opportunities for fulfilling part-time work (Directive to Take Action); and  
26 be it further  
27  
28 RESOLVED, that our American Medical Association study programs [such as WIN CUBED<sup>1</sup>]  
29 that enable timely follow-up after hospital discharge or ambulatory services by providing  
30 meaningful part-time work opportunities to late-career physicians (both semi-retired and retired).  
31 (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/16/26

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## RELEVANT AMA POLICY

### **D-160.905 Improvements to Patient Flow in the U.S. Healthcare System**

Our American Medical Association will work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system.

[Res. 709, A-24]

#### **11.1.3 Allocating Limited Health Care Resources**

Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:

- (a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.
- (b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).
- (c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).
- (d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.

AMA Principles of Medical Ethics: I,VII

*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*

[Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009  
(A-26)

Introduced by: Resident and Fellow Section

Subject: Preserving Access to Care for Undocumented Individuals

Referred to: Reference Committee on Ethics and Bylaws

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1 Whereas, the American Medical Association (AMA) recognizes migrant status as a determinant  
2 of health (D-60.966, H-65.938), and opposes measures that ostracize migrants from healthcare  
3 services (D-440.927) or positions of employment (H-65.932); and  
4

5 Whereas, our AMA opposes proposed rules, regulations, or policies that would deter immigrants  
6 from accessing healthcare (D-440.927) and opposes the criminalization of healthcare providers  
7 and systems who provide services to undocumented individuals (H-440.876); and  
8

9 Whereas, the One Big Beautiful Bill (OBBB) imposed sweeping Medicaid changes including  
10 reduced Medicaid reimbursement through the Federal Medical Assistance Percentages  
11 (FMAPs), and imposed penalties for states extending Medicaid coverage to undocumented  
12 individuals;<sup>1,2</sup> and  
13

14 Whereas, several states including Illinois, California, and Minnesota have rolled back, frozen  
15 enrollment, or ended coverage for undocumented individuals in response to fiscal pressures  
16 exacerbated by OBBB<sup>3,4,5,6</sup>; and  
17

18 Whereas, Massachusetts, one of the only states with a primarily state-funded safety net  
19 program for undocumented immigrants has expanded funding despite national trends to the  
20 opposite<sup>2</sup>; and  
21

22 Whereas, in 2019, approximately 20% of all uninsured individuals were undocumented with  
23 approximately 50% of all undocumented individuals lacking insurance<sup>7</sup>; therefore be it  
24

25 RESOLVED, that our American Medical Association study the impacts of the One Big Beautiful  
26 Bill on Medicaid-expansion and health safety net programs and insurance coverage for  
27 undocumented people with recommendations to improve healthcare coverage for  
28 undocumented individuals with a report back. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 4/21/26

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**RELEVANT AMA POLICY**

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

1. Our AMA opposes; a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; b. any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status; c. proof of citizenship as a condition of providing health care; and d. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25]

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

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

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
  - a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
  - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
  - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
  - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
  - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
  - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
  - g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
  - h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
  - a. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
  - b. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
  - c. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
  - d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24]

### **Reducing the Harmful Impacts of Immigration Status on Health H-65.932**

1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
3. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
4. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.

5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

#### **Guiding Principles for the Healthcare of Migrants H-65.938**

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

#### **Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966**

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. [Res. 016, A-17]

#### **Immigration Status in Medicaid and CHIP D-440.911**

Our American Medical Association advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. [Res. 210, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010  
(A-26)

Introduced by: Resident and Fellow Section

Subject: Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

Referred to: Reference Committee on Ethics and Bylaws

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- 1 Whereas, fatigue and sleep deprivation among intern, resident, and fellow physicians are well-  
2 documented contributors to motor vehicle accidents, threatening not only physician safety but  
3 also patient and public safety<sup>1,2</sup>; and  
4
- 5 Whereas, extended work hours and overnight shifts remain common in graduate medical  
6 education, leaving trainee physicians chronically vulnerable to fatigue-related harm when  
7 traveling to and from clinical sites<sup>3</sup>; and  
8
- 9 Whereas, the literature shows that driving while fatigued after an overnight or extended shift  
10 impairs sustained attention and vigilance to a degree comparable to alcohol intoxication,  
11 substantially increasing the risk of motor vehicle accidents<sup>4-5</sup>; and  
12
- 13 Whereas, the Accreditation Council for Graduate Medical Education (ACGME) recognizes  
14 physician well-being as a critical institutional responsibility and mandates strategies to mitigate  
15 fatigue<sup>6</sup>; and  
16
- 17 Whereas, ACGME policy 6.16 explicitly requires that “the program, in partnership with its  
18 Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for  
19 residents who may be too fatigued to safely return home”<sup>7</sup>; and  
20
- 21 Whereas, implementation of this policy remains inconsistent across residency and fellowship  
22 programs nationwide, leaving many trainee physicians (who often have limited financial  
23 resources) without access to safe, reliable, and funded transportation when fatigued; and  
24
- 25 Whereas, a study of a university-affiliated general surgery residency program demonstrated that  
26 a low-cost rideshare reimbursement initiative significantly reduced residents’ self-reported  
27 frequency of falling asleep or nearly falling asleep while driving, illustrating a clear, evidence-  
28 based intervention<sup>8</sup>; and  
29
- 30 Whereas, some residency and fellowship programs, such as those at the University of  
31 California, Los Angeles, provide fully-funded rideshare access for travel to and from the hospital  
32 surrounding shifts<sup>9</sup>; and  
33
- 34 Whereas, such resources are neither consistently available nor equitably funded nationwide,  
35 creating gaps in the safety of trainee physicians and underscoring the need for coordinated  
36 action at the national level; therefore be it  
37
- 38 RESOLVED, that our American Medical Association supports the provision of fully-funded  
39 transportation options (including, but not limited to, rideshares and taxis) for intern, resident, and

40 fellow physicians after extended or overnight shifts as a core fatigue mitigation strategy, with  
 41 costs not borne by trainees. (New HOD Policy)  
 42

Fiscal Note: Minimal – less than \$5,000

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#### RELEVANT AMA POLICY

##### Residents and Fellows' Bill of Rights H-310.912

With regard to benefits, residents and fellows must be fully informed of and should receive: Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues. Confidential access to mental health and substance abuse services. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks. Leave in compliance with the Family and Medical Leave Act. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24; Modified: Res. 304, I-24]

##### Resident/Fellow Clinical and Educational Work Hours H-310.907

Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to

include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
  - a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
  - b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
  - c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
  - d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
  - a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
  - b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
  - c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
  - d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
  - a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
  - b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
  - c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
  - d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
  - e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
  - f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.

- g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
  - h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
  - i. Scheduled time providing patient care services of limited or no educational value should be minimized.
  - j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
  - k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
  - l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
  - m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
  - n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
  - o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

[CME Rep. 5, A-14 Modified: CME Rep. 06, I-18 Reaffirmation: A-22]

#### **Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958**

1. Our American Medical Association recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.
2. Our AMA recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
3. Our AMA recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
4. Our AMA encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.

5. Our AMA urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
6. Our AMA recommends that physicians:
  - a. become knowledgeable about the diagnosis and management of sleep-related disorders.
  - b. investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories.
  - c. inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries.
  - d. advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery.
  - e. inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries.
  - f. become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
7. Our AMA encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
8. Our AMA recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
9. Our AMA reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

[CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19; Reaffirmation: A-22]