

Reference Committee on Amendments to Constitution and Bylaws

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-22

Subject: Opposition to Requirements for Gender-Based Treatments for Athletes
(Resolution 19-A-19)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Resolution 19-A-19, “Opposition to Requirements for Gender-Based Treatment for Athletes,”
2 sponsored by the Medical Student Section, was referred to the Board of Trustees. Resolution 19-A-
3 19 asked:

- 4
5 1. That our American Medical Association (AMA) oppose any regulations requiring
6 mandatory medical treatment or surgery for athletes with Differences of Sex Development
7 (DSD) to be allowed to compete in alignment with their identity; (New HOD Policy) and
8
- 9 2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender
10 classification for athletic competitions. (New HOD Policy)
11

12 BACKGROUND

13
14 Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics
15 Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with
16 differences of sex development (DSD) who wish to compete as women in certain international
17 track and field events. Under these guidelines, to be eligible to compete in the 400m, hurdles races,
18 800m, 1500m, one-mile races and combined events over the same distances, women with DSD
19 who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- 20
21 • be legally recognized as female or intersex
- 22 • reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous
23 period of 6 months, and
- 24 • maintain their serum testosterone level below 5 nmol/L continuously for as long as they
25 wish to remain eligible to compete (regardless of whether they are in competition) [1].
26

27 Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible
28 to compete in all events that are not international competitions and in events in international
29 competitions other than those specifically prohibited [1].
30

31 In a separate report, World Athletics outlines eligibility criteria for transgender athletes competing
32 in international competitions. They specify that
33

- 34 • to be eligible to participate in the female category of competition, a transgender female
35 athlete must provide a written and signed declaration that her gender identity is female;

- 1 • she must demonstrate to the satisfaction of an expert panel that the concentration of
2 testosterone in her serum has been less than 5 nmol/L continuously for a period of at least
3 12 months; and
- 4 • she must keep her serum testosterone concentration below 5 nmol/L for so long as she
5 wishes to maintain her eligibility to compete in the female category [2].
6

7 They further specify that “no athlete will be forced to undergo any medical assessment and/or
8 treatment” and that neither “legal recognition of the athlete's gender identity” nor “surgical
9 anatomical changes” are required to compete [2].
10

11 These guidelines represent the most recent in a series of efforts by the international athletic
12 community to ensure fairness in women’s competitions that began with “gender verification”
13 policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press in
14 the 1960 and 1964 Olympics, who were suspected of being male, female athletes were required to
15 prove their sex to be eligible to compete as women in international events [3]. Over time,
16 procedures to determine sex evolved from having female athletes parade naked before a panel of
17 judges, through gynecological examination of external genitalia, to the use of sex chromatin tests,
18 and ultimately DNA-based testing [3]. In 2000, the International Olympic Committee (IOC) and
19 IAAF discontinued routine gender verification in favor of “suspicion-based testing,” reserving the
20 right to test if officials or competitors raised questions about a female athlete’s sex.
21

22 In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC’s Medical
23 Commission recommended hormone-based testing, that is, that individuals recognized in law as
24 female be eligible to compete in women’s competitions so long as their serum testosterone levels
25 were “below the male range” or if they had an androgen resistance and derived no competitive
26 advantage from testosterone levels in the male range [3]. The IAAF adopted hormonal testing and
27 implemented new policy that routinely tested all female athletes and required those who tested
28 outside the normal range to undergo treatment to normalize their androgen levels to be eligible to
29 compete.
30

31 In March 2019 the United Nations Human Rights Council adopted Resolution 40/5, “Elimination
32 of discrimination against women and girls in sport,” noting concern that the IAAF/World Athletics
33 eligibility criteria
34

35 are not compatible with international human rights norms and standards, including the rights of
36 women with differences of sex development, and concerned at the absence of legitimate and
37 justifiable evidence for the regulations to the extent that they may not be reasonable and
38 objective, and that there is no clear relationship of proportionality between the aim of the
39 regulations and the proposed measures and their impact [4].
40

41 The resolution further expressed concern that
42

43 discriminatory regulations, rules and practices that may require women and girl athletes with
44 differences of sex development, androgen sensitivity and levels of testosterone to medically
45 reduce their blood testosterone levels contravene international human rights norms and
46 standards ... [4]
47

48 In 2021 the IOC amended its stance and issued a new “Framework on Fairness, Inclusion and Non-
49 Discrimination on the Basis of Gender Identity and Sex Variations” that eliminated specific
50 instructions on eligibility to compete [5]. Rather, the framework sought to offer general guidance to
51 sports governing bodies:

1 to promote a safe and welcoming environment for everyone, consistent with the principles
2 enshrined in the Olympic Charter; it “acknowledges the central role that eligibility criteria play
3 in ensuring fairness, particularly in high-level organized sport in the women’s category” [5].
4

5 With the framework, the IOC recognized “that it is not in a position to issue regulations that define
6 eligibility for every sport” and explicitly left it “to each sport and its governing body to determine
7 how an athlete may be at disproportionate advantage to their peers” [5].
8

9 Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its
10 eligibility criteria published a correction in response to ongoing critique from independent
11 statisticians. The correction acknowledged that “there is no confirmatory evidence for causality in
12 the observed relationships reported” [6]. The authors further noted that the initial research was
13 “exploratory and not intend[ed] to prove a causal influence and that some statements in the original
14 publication could have been misleading” [6].
15

16 World Athletics has not modified its criteria [6], however, and controversy regarding participation
17 by female athletes with DSD continues.
18

19 The related controversy concerning participation of transgender athletes in all types of sports has
20 escalated in recent years. Since 2020, a number of state legislatures have introduced proposals to
21 prohibit transgender girls from competing in girls’ high school (and in some cases college) sports.
22 In March 2020, Idaho was the first state to impose a ban on transgender women and girls’
23 participation in school sports. In 2021, Alabama, Arkansas, Florida, Mississippi, Montana,
24 Tennessee, and West Virginia passed similar bans, and South Dakota’s governor issued two
25 Executive Orders which implemented a similar prohibition. At the same time the Connecticut court
26 case *Soule et al v. CT Association of Schools et al* was in process. In this case the Alliance
27 Defending Freedom sought to ban two Black, transgender girls from competing in high school
28 track and field [7].
29

30 The Idaho ban was blocked by a federal court in August 2020. The AMA, along with the American
31 Academy of Pediatrics and other health care organizations, submitted an amicus brief with the
32 Ninth Circuit Court of Appeals noting that the law undermines the accepted approach for treating
33 gender dysphoria. The brief stated that prohibiting transgender females from participating in
34 school-sponsored sports in keeping with their gender identity interferes with the treatment of
35 gender dysphoria by preventing transgender females from living openly in accordance with their
36 true gender [8].
37

38 The AMA, together with five other healthcare organizations, also submitted an amicus brief in
39 *Soule et al v. CT Association of Schools et al*. In it, they emphasize that untreated gender dysphoria
40 can cause debilitating distress, depression, impairment of function, self-mutilation, other self-
41 injurious behaviors, and suicide. They also note that transgender individuals are subject to
42 discrimination in multiple areas of their lives, and this both exacerbates negative health outcomes
43 and reinforces the stigma associated with being transgender. Being subject to stigmatization is
44 psychologically harmful and so creates additional negative mental health consequences [9].
45

46 *Soule et al* was dismissed at the state level and (as of August 2022) an appeal in the 2nd Circuit
47 Court remains undecided. As of May 2022, eighteen states have enacted laws or issued rules that
48 either ban or limit the participation of transgender athletes in public school sports [10]. As a result,
49 in some states regulations are more restrictive at lower levels of competition and in recreational
50 programs than they are at higher levels.

For instance, the IOC guidelines amended in 2021 reflect an inclusive and non-discriminatory position with respect to transgender athletes, consistent with their guidelines for athletes with DSDs. They state that

- eligibility criteria should be established and implemented fairly and in a manner that does not systematically exclude athletes from competition based upon their gender identity, physical appearance and/or sex variations;
- no athlete should be subject to targeted testing because of, or aimed at determining, their sex, gender identity and/or sex variations;
- athletes should not be pressured to undergo medically unnecessary procedures or treatment to meet eligibility criteria; and
- criteria to determine eligibility should not include gynecological examinations or other invasive physical examinations aimed at determining an athlete's gender or sex [5].

FAIRNESS IN SPORT

Regulations intended to promote fairness in sport by restricting the participation of individuals whose genetic characteristics are deemed to give them unfair advantage over competitors raise a series of questions about what the goals of sport are, what counts as an “unfair” advantage, and what should be done to “level the playing field.”

Biological Advantage

Policy restricting competition by female athletes who have serum testosterone levels above a designated “normal” range rests on (at least) two problematic assumptions. The first of those assumptions is that there is a straightforward relationship between testosterone and athletic performance that unequivocally gives these athletes significant advantage over female competitors whose bodies do not produce “excess” endogenous testosterone. The second is that serum testosterone levels can meaningfully be measured, and that prescribed levels can be safely and effectively maintained. The specific contribution of testosterone to overall athletic performance continues to be a subject of debate. Critics of the research on which the IAAF based its regulations on endogenous testosterone have argued that a key study concluding that women with the highest testosterone levels significantly and consistently outperformed other female competitors rests on flawed data [11]. Concerns have also been raised about the rigor of its statistical analysis [12]. The main author, moreover, was the director for the IAAF Science and Health Department, raising questions about possible conflict of interest [13]. More importantly, demonstrating a correlation between testosterone and athletic performance in female athletes falls short of establishing the unfairness of such advantage [13].

However, even if the effect of testosterone on athletic performance was conclusively established, single point-in-time tests for overall level of serum testosterone cannot provide conclusive evidence that the individual has or will benefit. It is known that women with androgen insensitivity disorder physiologically cannot gain benefit from excess endogenous testosterone. Multiple factors affect serum concentrations of testosterone, including time of day; age- and gender-corrected normal ranges using a standard assay have not been established; and there is no universally recognized standard for calibrating testosterone [14].

Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the “bio-testosterone”) is not well understood” [15]. Nor do the IAAF regulations take into account the existing lack of consensus about “how to use medications safely to lower testosterone levels when

used off-label, the side effects of the medications, [or] the difficulties of maintaining the testosterone levels below the levels requested by IAAF owing to natural fluctuations” [13].

Leveling the Playing Field

Assuming, for purposes of analysis, that testosterone does confer a significant competitive advantage in sport, knowing that does not in itself determine what steps should be taken to “level the playing field.” The latter decision is a normative matter, not an empirical one.

To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair advantage over competitors requires that rules treat all relevantly similar advantage-conferring attributes in a like manner. Testosterone testing for female athletes who have been singled out on the basis of their appearance or performance for all practical purposes subjects these individuals to genetic testing not imposed on their competitors.

Fairness would require that sports organizations test for *any* “performance enhancing genes that predispose [individual athletes] to be athletically superior” [16]. In the present state of knowledge, this is no more realistic an approach than are current testosterone assays. The influence of genetic factors on athletic performance is multifactorial and sport specific [17]. Organizations would further have to regulate all such advantage-conferring attributes consistently.

One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable (fair) or dynamic (unfair) [18]. Fair advantages are those the athlete largely cannot affect, (such as chronological age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as speed, strength, endurance, etc.). On this account, genetic differences in testosterone would be stable advantages that could be subject to leveling or more fine-grained classification.

Thinking specifically about leveling the playing field with respect to inequalities in testosterone levels, three approaches present themselves [13]. First, sports organizations could require athletes to lower testosterone levels that exceed a defined threshold to below a predetermined level. Second, organizations could create separate categories for competition based on the level of biological variations, allowing all athletes with serum testosterone within a certain range to compete against one another, regardless of sex or gender identification [13]. Or, third, they could create categories based on modifying the external conditions of competition instead of intervening in athletes’ bodies. Handicapped horse racing offers a model [13].

THE ROLE OF PHYSICIANS

World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of transgender athletes and athletes with DSDs. In doing so, they virtually require the participation of physicians helping athletes achieve and maintain the stipulated levels of serum testosterone. To the extent that medical interventions to lower testosterone may not be *clinically* indicated, is physician participation appropriate? Overall, existing policies of the American Medical Association and the World Medical Association (WMA) argue against physicians cooperating in the implementation of these regulations.

Existing AMA policy in H-470.978, “[Blood Doping](#),” and H-470.976, “[Abuse of Anabolic Steroids](#),” prohibit physician participation in blood doping or prescribing anabolic steroids. H-470.994, “[Non-Therapeutic Use of Pharmacological Agents by Athletes](#),” opposes the use of interventions to enhance athletic performance but is silent with respect to physicians’ specific responsibilities.

[Principle VIII](#) of the AMA *Principles of Medical Ethics* states that “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” Opinion 1.2.5, “[Sports Medicine](#),” in the AMA *Code of Medical Ethics* limits its focus to physicians present during athletic events. It directs those who “serve in a medical capacity at athletic, sporting, or other physically demanding events should protect the health and safety of participants.” This is particularly relevant to minors who wish to participate in sports in line with their gender identity, since CEJA Report 3-I-18 “Pediatric Decision-making” specifies that the best interests of a minor should be “understood broadly” and treatment decisions should be made in light of “likely impact on the child’s psychosocial wellbeing”[19]. Opinion 5.5, “[Medically Ineffective Interventions](#),” which specifically addresses the use of life-sustaining interventions in contexts of terminal illness, provides that physicians “should only recommend and provide interventions that are medically appropriate.” It also notes that patients should not receive specific interventions simply because they request them.

Further, Opinion 8.5, “[Disparities in Health Care](#),” states that “differences in treatment that are not directly related to individual patients’ clinical needs or preferences constitute inappropriate variations in health care.” This can be construed as ruling out unnecessary testing or alteration of treatment related to gender identity when these are required by third parties for participation in sports. In Opinion 1.1.2, “[Prospective Patients](#),” physicians are required to refrain from discrimination on the basis of gender and gender identity, which in accordance with principles of justice, should extend to declining to participate in (and so refusing to legitimize) discriminatory practices that violate patients’ human rights.

In a press release in April 2019, the [World Medical Association](#) demanded that the IAAF “immediately withdraw” its new eligibility regulations for classifying female athletes and urged physicians to “take no part” in implementing them. In October 2021 WMA updated “[Declaration on Principles of Health Care in Sports Medicine](#)” to oppose World Athletics eligibility regulations and condemn “medical treatment solely to alter athletic performance,” as “unethical.”

These provide strong arguments that, as professionals committed to promoting first and foremost the well-being of their patients, it is not appropriate for physicians to provide medical interventions required to fulfill the World Athletics regulations mandating specific testosterone levels for either athletes with DSDs or transgender athletes. These arguments also suggest it is inappropriate for a physician to cooperate with any public school or recreational team that requires medical testing and/or physician confirmation that an athlete is a particular gender in order for them to participate.

RECOMMENDATION

In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) oppose mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity; (New HOD Policy)
2. That our AMA oppose the use of specific hormonal guidelines to determine gender classification for athletic competitions. (New HOD Policy)

- 1 3. That our AMA oppose physician participation in any practices intended to officially certify or
2 confirm an athlete's gender for the purposes of satisfying third party requirements. (New HOD
3 Policy)

Fiscal note: Less than \$500.

REFERENCES

1. International Amateur Athletics Federation. *Eligibility Regulations for the Female Classification (Athletes with Differences of Sex Development)*. May 2019. Available at <https://www.sportsintegrityinitiative.com/wp-content/uploads/2019/05/IAAF-Eligibility-Regulations-for-the-Female-Classi-2-compressed.pdf>. Accessed February 28, 2020.
2. World Athletics. *Eligibility Regulations for Transgender Athletes*. October 2019. Available at: <https://www.worldathletics.org/download/download?filename=ace036ec-a21f-4a4a-9646-fb3c40fe80be.pdf&urlslug=C3.5%20%20Eligibility%20Regulations%20Transgender%20Athletes>. Accessed August 1, 2022.
3. Sullivan CF. Gender verification and gender policies in elite sport: eligibility and “fair play.” *Journal of Sport and Social Issues* 2011;35(4) 400–419.
4. United Nations Human Rights Council. *Resolution 40/5 Elimination of discrimination against women and girls in sport*, 2021. Available at <https://www.right-docs.org/doc/a-hrc-res-40-5/>. Accessed March 23, 2022.
5. International Olympic Committee. *IOC Framework on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations*, 2021. Available at https://stillmed.olympics.com/media/Documents/News/2021/11/IOC-Framework-Fairness-Inclusion-Non-discrimination-2021.pdf?_ga=2.22929395.911782377.1648130991-1468664224.1648130991. Accessed March 23, 2022.
6. Berman S, Garnier P-Y. Correction: Serum androgen levels and their relation to performance in track and field: mass spectrometry results from 2127 observations in male and female elite athletes. *Br J Sports Med* 2021;55:e7.
7. Sharrow E. Sports, transgender rights and the bodily politics of cisgender supremacy. *Laws* 2021;10:63-91. See also *Brief of Amici Curiae American Medical Association, et al., Hecox v. Little*, No. 2035813 (9th Cir. Dec. 21, 2020), available at https://searchlf.ama-assn.org/case/documentDownload?uri=%2Funstructured%2Fbinary%2Fcasebriefs%2FHecox_v_Little_Ninth_Circuit_Court_of_Appeals_Brief.pdf
8. American Medical Association. AMA Advocacy Update, March 26, 2022. Available at: <https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update> Available at: <https://www.aclu.org/cases/soule-et-al-v-ct-association-schools-et-al>. Accessed August 1, 2022. See also *Brief of Amici Curiae American Medical Association, et al., Soule v. Connecticut Ass’n of Schs.*, No.21-1365 (2d Cir. Oct. 12, 2021), available at https://searchlf.ama-assn.org/case/documentDownload?uri=%2Funstructured%2Fbinary%2Fcasebriefs%2FSoule_v_CIAC_Second_Circuit_Court_of_Appeals_Brief.pdf.
9. American Academy of Pediatrics, American Medical Association, American Women's Association, et al. *Amicus Briefs in Support of Defendants-Appellees.* .
10. Chen D. Transgender athletes face bans from girls’ sports in 10 states. *New York Times*; updated May 24, 2022. Available at: <https://www.nytimes.com/article/transgender-athlete-ban.html>. Accessed August 1, 2022.
11. Harper J. Transgender athletics and international sports policy. *Law and Contemporary Problems* 2022;85:151-165. Available at <https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5035&context=lcp>. Accessed March 23, 2022.
12. Pielke R, Tucker R, Boye E. Scientific integrity and the IAAF testosterone regulations. *International Sports Law Journal* 2019; 19:18-26. Available at <https://link.springer.com/content/pdf/10.1007/s40318-019-00143-w.pdf>. Accessed February 28, 2020.

13. Franklin S, Betancurt JO, Camporesi S. What statistical data of observational performance can tell us and what they cannot: the case of *Dutee Chand v. AFI & IAAF*. *Br J Sports Med* 2018;52(7):420-421.
14. Camporesi S. When does an advantage become unfair? Empirical and normative concerns in Semenya's case. *J. Med Ethics* 2019;0:1-5.
15. Wylie K, Rees M, Hackett G, et al. Androgens, health and sexuality in women and men. *Maturitas* 2010;67:275-289.
16. Bostwick JM, Joyner MJ. The limits of acceptable biological variation in elite athletes: should sex ambiguity be treated differently from other advantageous genetic traits? *Mayo Clin Proc.* 2012;87(6):508-513.
17. Cooky C, Dworkin SL. Policing the boundaries of sex: a critical examination of gender verification and the Caster Semenya controversy. *J Sex Research* 2013;50(2):103-111.
18. Guth LM, Roth SM. Genetic influence on athletic performance. *Curr Opin Pediatr* 2013;25:653-658.
19. CEJA Report 3-I-18, Amendment to E-2.2.1. 2019.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-22

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

At June's Annual Meeting, Board of Trustees Report 20 was considered, with the following recommendations referred for report at this meeting (to avoid confusion with the original recommendations, letters are used here to designate the recommendations):

- A. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-end AMA membership data as recorded by the AMA.
- B. That delegate apportionment for 2024 be based on then current bylaws.
- C. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these recommendations, with the report to be considered no later than the November 2022 meeting of the House of Delegates.
- D. That Policy G-600.016, "Data Used to Apportion Delegates," be rescinded.

The following recommendation from the same report was referred for decision.

- E. That pending members no longer be considered in apportioning delegates in the House of Delegates.

The recommendations labelled A-D above hinged on Recommendation E, which would have ceased counting pending members for apportionment purposes. By and large Recommendations A-D could be considered to have been subordinate to or contingent on Recommendation E.

PENDING MEMBERS DEFINED

Essential to dealing with the matter of pending members is the definition. Board Report 1-I-18 defined pending members as individuals who are not current members at the time they pay their dues for the following calendar year. Two elements are required: the person is not a current member at the time of dues payment and the person joins for the following calendar year. The report had been prepared in response to a proposal to count these pending members for delegate apportionment. To prevent gaming the system, by for example joining only every other year, the House determined that a pending member would be counted for apportionment purposes the following year if and only if they had again paid their dues early (i.e., before year end).

FOLLOW ON ACTION

As noted, Recommendation E (originally the first of six recommendations in the Board's report) was referred for decision. Acting in September, the Board adopted this recommendation, meaning pending members will not be counted for apportionment purposes. As a practical matter, once someone becomes a pending member, the individual must be tracked across time in perpetuity

solely for apportionment. Say an individual becomes a pending member in Year 0, meaning they will be an actual member in Year 1. To be counted for apportionment purposes in Year 2, the pending member must have paid their dues for Year 2 in Year 1. That will be true for successive years without end (pay for Year 3 in Year 2, for Year 4 in Year 3, and so on). Note that a current member (who has never been counted as a pending member) who always pays dues “early” is not a pending member.

If that pending member’s dues payment is delayed to January 1 (or later) of Year 2, they will not have been counted in apportioning Year 2 delegates but will be counted at the end of Year 2 for Year 3 as a regular member, NOT as a pending member. At that point, the individual is a regular member unless their membership lapses and they cycle back into the pending member category. In other words, the timing of one’s dues payment and one’s membership status at the time of that payment affect how and whether one is counted for apportionment purposes. These elements cannot be captured by AMA’s membership accounting system across a potential 40- or 50-year career in medicine. To track the information would require an estimated quarter million dollar change to the membership accounting system.

Your Board acknowledges the arguments for counting pending members but believes counting them not only unnecessarily complicates the apportionment process but that it devalues other benefits of membership and active members themselves:

- The notion that pending members gain representation only by being counted for apportionment purposes belies the fact that delegates represent the needs of not only members but patients, their sponsoring societies, and the profession, including nonmembers.
- Suggestions that being counted toward representation in the House of Delegates is attractive are speculative at best. Physicians consistently report valuing the advocacy that emerges from House of Delegates policy, not the House of Delegates per se.
- Pending members are in fact NOT members. Individuals who join late in the year wishing to be counted—a premise that is largely unsupported—could easily join for the current year by paying half-year dues.
- Some have argued that not counting pending members is tantamount to treating them as second-class members. As just noted, they are not members, at least not initially, but decisions about apportionment need not be linked to more concrete member benefits, which are a separate business decision that can and should be addressed as a membership matter.
- Finally, no evidence has emerged to suggest that the offer to count pending members for apportionment purposes has led to membership gains. Virtually all the pending members in the initial implementation had joined prior to the implementation of the experiment. Few states gained delegates, meaning few have benefitted if at all.

While the makeup of the House is the province of the House, your Board believes that the longstanding policy of counting actual members for apportionment has served our members well. Counting pending members can be considered to diminish or discount actual members’ value as much as it can be seen to enhance representation.

POLICY ADOPTED AT A-22

The following policy was adopted at June’s Annual Meeting and is the subject of Report 1 from the Council on Constitution and Bylaws at this meeting. The policy was adopted in lieu of a proposal to extend the delegate freeze into 2023. If implemented—bylaws amendments are required—in 2023 constituent societies will be apportioned delegates using the following formula, whereby each society will get the greatest of the three calculated numbers:

- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5.

Although implementation depends on action to be taken at this Interim Meeting, your Board would emphasize that this plan, which originated with the Board's report, was based on counting actual members and was intended not to continue counting pending members. In addition, the Board's action on the item referred for decision means pending members will not be counted for apportionment purposes.

REFERRED ITEMS

Turning to the four referred items, each will be dealt with in turn. Recommendation A (as labelled herein) called for constituent society apportionment in 2023 to be based on "official 2022 year-end membership data" and simply flowed from the recommendation that preceded it to not count pending members. That latter recommendation, labelled "E" in this report, has been adopted by Board action. Existing bylaws or possible amendments at this meeting will suffice. No action is therefore required on the referred recommendation.

Recommendation B calling for delegate apportionment in 2024 to be based on then current bylaws is unnecessary. Current bylaws are by definition controlling. Moreover, the language does not affect the ability of the House to amend bylaws, so again, no action is required.

The recommendation in Board of Trustees Report 20-A-22 calling for the Council on Constitution and Bylaws to prepare a report essentially flagged the Council that bylaws amendments might be necessary. It is more a style for AMA reports than a necessity, as the Council has the authority to generate and offer reports on its own. The recommendation requires no action.

The fourth referred recommendation, labelled D, was simply a housekeeping matter, meant to cull an unneeded policy from the compendium, which contains 3955 separate policy statements. Policy G-600.016, "Data Used to Apportion Delegates," reads as follows:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

1 Paragraphs two and three of the policy are not relevant if pending members are no longer counted.
2 Paragraph four was fulfilled by Board of Trustees Report 20-A-22, even though all but one of the
3 recommendations it contained were referred. While a case might be made for retaining paragraph
4 one, our AMA's Federation Relations and Membership units are in regular communication with
5 societies in the House, and any society can easily request its current data at any time. For specialty
6 societies not undergoing their five-year review, the report has no value, and little need for a
7 mandated report is apparent. Consequently, the policy is recommended for rescission.

8
9 RECOMMENDATION

10
11 Your Board is cognizant of the fact that some members of the House believe that counting pending
12 members is beneficial to membership and acknowledges the right of the House to determine its
13 makeup. Nevertheless, your Board has concluded that counting pending members for
14 apportionment lacks merit for the reasons outlined above. Also worth noting is that the House will
15 act on Council on Constitution and Bylaws Report 1, which will determine the path taken and may
16 also affect action on this report.

17
18 Your Board of Trustees recommends that Policy G-600.016 be rescinded and the remainder of the
19 report filed.

Fiscal Note: \$150 to update PolicyFinder

REPORT 4 OF THE BOARD OF TRUSTEES (I-22)
Preserving Access to Reproductive Health Services
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

At the 2022 American Medical Association (AMA) Annual Meeting, our AMA House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which, among other things, instructs the AMA to review the AMA policy compendium and recommend policies to be amended or rescinded. This Board report, therefore, reviews AMA policy related to reproductive health, discusses policies for amendment or rescission, and provides recommendations.

In its review of the policy compendium, the Board identified three duplicative policies and recommends these policies be consolidated into one policy. The report also recommends modifying two policies related to physicians’ personal views on abortion and clinical determinations about the viability of a fetus to conform with new policy adopted at the 2022 Annual Meeting. Finally, the report recommends modifying policy to remove a reference to *Roe v. Wade*.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-22

Subject: Preserving Access to Reproductive Health Services

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 INTRODUCTION

2
3 At the 2022 American Medical Association (AMA) Annual Meeting (2022 Annual Meeting), our AMA
4 House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which
5 states:

6
7 That our AMA:

- 8 1. Recognizes that healthcare, including reproductive health services like contraception and
9 abortion, is a human right;
- 10 2. Opposes limitations on access to evidence-based reproductive health services, including
11 fertility treatments, contraception, and abortion;
- 12 3. Will work with interested state medical societies and medical specialty societies to vigorously
13 advocate for broad, equitable access to reproductive health services, including fertility
14 treatments, contraception, and abortion;
- 15 4. Supports shared decision-making between patients and their physicians regarding
16 reproductive healthcare;
- 17 5. Opposes any effort to undermine the basic medical principle that clinical assessments, such as
18 viability of the pregnancy and safety of the pregnant person, are determinations to be made
19 only by healthcare professionals with their patients;
- 20 6. Opposes the imposition of criminal and civil penalties or other retaliatory efforts against
21 patients, patient advocates, physicians, other healthcare workers, and health systems for
22 receiving, assisting in, referring patients to, or providing reproductive health services;
- 23 7. Will advocate for legal protections for patients who cross state lines to receive reproductive
24 health services, including contraception and abortion, or who receive medications for
25 contraception and abortion from across state lines, and legal protections for those that
26 provide, support, or refer patients to these services;
- 27 8. Will review the AMA policy compendium and recommend policies which should be
28 amended or rescinded to reflect these core values, with report back at I-22.

29
30 This Board report, therefore, addresses paragraph 8 of the policy, reviews AMA policy related to
31 reproductive health, discusses policies for amendment or rescission, and provides recommendations.

AMA POLICY

Our AMA has many policies addressing access to abortion and other reproductive health care services. These policies, including those adopted or amended during the 2022 Annual Meeting, are as follows:

Policy D-5.999, “Preserving Access to Reproductive Health Services”

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22. (Res. 028, A-22)

Policy H-5.995, “Abortion”

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of this state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20)

Policy H-5.993, “Right to Privacy in Termination of Pregnancy”

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities. (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14)

1 *Policy H-5.983, “Pregnancy Termination”*

2 The AMA adopted the position that pregnancy termination be performed only by appropriately
3 trained physicians (MD or DO). (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH
4 Rep. 1, A-13)

5
6 *Policy H-5.990, “Policy on Abortion”*

7 The issue of support of or opposition to abortion is a matter for members of the AMA to decide
8 individually, based on personal values or beliefs. The AMA will take no action which may be
9 construed as an attempt to alter or influence the personal views of individual physicians regarding
10 abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep.
11 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03,
12 A-19)

13
14 *Policy H-5.988, “Accurate Reporting on AMA Abortion Policy”*

15 Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of
16 the House of Delegates to precisely state current AMA policy on abortion and related issues in an
17 effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to
18 refute misstatements and misquotes by the media with reference to AMA abortion policy.
19 (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed:
20 CEJA Rep. 1, A-21)

21
22 *Policy H-5.989, “Freedom of Communication Between Physicians and Patients”*

23 It is the policy of the AMA: (1) to strongly condemn any interference by the government or other
24 third parties that causes a physician to compromise his or her medical judgment as to what
25 information or treatment is in the best interest of the patient;
26 (2) working with other organizations as appropriate, to vigorously pursue legislative relief from
27 regulations or statutes that prevent physicians from freely discussing with or providing information to
28 patients about medical care and procedures or which interfere with the physician-patient relationship;
29 (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on
30 physician-patient communications; and
31 (4) to inform the American public as to the dangers inherent in regulations or statutes restricting
32 communication between physicians and their patients.
33 (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-
34 96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-
35 98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09;
36 Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

37
38 *Policy H-100.948, “Supporting Access to Mifepristone (Mifeprex)”*

39 Our AMA will support mifepristone availability for reproductive health indications, including via
40 telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug
41 Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.
42 (Res. 504, A-18; Modified: Res. 27, A-22)

43
44 *Policy H-140.835, “Political Interference in the Patient-Physician Relationship”*

45 Our AMA opposes any policies that interfere with the patient-physician relationship by giving
46 probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or
47 imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of
48 beneficiaries. (Alt. Res. 007, I-17)

1 *Policy H-5.998, “Public Funding of Abortion Services”*

2 The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care
3 funding mechanisms to deny established and accepted medical care to any segment of the population.
4 (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed:
5 CMS Rep. 1, A-15)

6
7 *Policy H-425.969, “Support for Access to Preventive and Reproductive Health Services”*

8 Our AMA supports access to preventive and reproductive health services for all patients and opposes
9 legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny
10 established and accepted medical care to any segment of the population.
11 (Sub. Res. 224, I-15 Reaffirmation: I-17)

12
13 *Policy H-185.937, “Reproductive Parity”*

14 Our AMA supports legislation and policies that require any health insurance products offering
15 maternity services to include all choices in the management of reproductive medical care.
16 (Res. 4, I-13)

17
18 *Policy H-295.923, “Medical Training and Termination of Pregnancy”*

19 1. Our AMA supports the education of medical students, residents and young physicians about the
20 need for physicians who provide termination of pregnancy services, the medical and public health
21 importance of access to safe termination of pregnancy, and the medical, ethical, legal and
22 psychological principles associated with termination of pregnancy.
23 2. Our AMA supports the availability of abortion education and exposure to procedures for
24 termination of pregnancy, including medication abortions, for medical students and resident/fellow
25 physicians and opposes efforts to interfere with or restrict the availability of this education and
26 training.
27 3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently
28 enforce compliance with the standardization of abortion training opportunities as per the requirements
29 set forth by the Review Committee for Obstetrics and Gynecology and the American College of
30 Obstetricians and Gynecologists’ recommendations. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04;
31 Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified:
32 Res. 309, I-21)

33
34 *Policy H-5.980, “Oppose the Criminalization of Self-Induced Abortion”*

35 Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of
36 patients who access abortions as it increases patients’ medical risks and deters patients from seeking
37 medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-
38 managed abortion and the criminalization of patients who access abortions; and (3) will oppose
39 efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and
40 requirements that physicians function as agents of law enforcement—gathering evidence for
41 prosecution rather than as a provider of treatment. (Res. 007, A-18; Modified: Res. 27, A-22)

42
43 *Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”*

44 (1) It is AMA’s position that any entity that represents itself as offering health-related services should
45 uphold the standards of truthfulness, transparency, and confidentiality that govern health care
46 professionals.
47 (2) Our AMA urges the development of effective oversight for entities offering pregnancy related
48 health services and counseling.
49 (3) Our AMA advocates that any entity offering crisis pregnancy services

1 a. truthfully describes the services they offer or for which they refer—including prenatal care,
2 family planning, termination, or adoption services—in communications on site and in their
3 advertising, and before any services are provided to an individual patient; and
4 b. be transparent with respect to their funding and sponsorship relationships.

5 (4) Our AMA advocates that any entity licensed to provide medical or health services to pregnant
6 women

7 a. ensure that care is provided by appropriately qualified, licensed personnel; and

8 b. abides by federal health information privacy laws.

9 (5) Our AMA urges that public funding only support programs that provide complete, non-directive,
10 medically accurate, health information to support patients informed, voluntary decisions.

11 (Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21; Modified: BOT Rep. 14, A-22)

12
13 *Policy H-5.982, “Late-Term Pregnancy Termination Techniques”*

14 (1) The term 'partial birth abortion' is not a medical term. The AMA will use the term “intact
15 dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the following
16 elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual
17 conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and
18 partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but
19 otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures
20 more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not
21 a medical term it will not be used by the AMA.

22 (2) According to the scientific literature, there does not appear to be any identified situation in which
23 intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been
24 raised about intact D&X. The AMA recommends that the procedure not be used unless alternative
25 procedures pose materially greater risk to the woman. The physician must, however, retain the
26 discretion to make that judgment, acting within standards of good medical practice and in the best
27 interest of the patient.

28 (3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy.
29 In the second trimester when viability may be in question, it is the physician who should determine
30 the viability of a specific fetus, using the latest available diagnostic technology.

31 (4) In recognition of the constitutional principles regarding the right to an abortion articulated by the
32 Supreme Court in *Roe v. Wade*, and in keeping with the science and values of medicine, the AMA
33 recommends that abortions not be performed in the third trimester except in cases of serious fetal
34 anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the
35 life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in
36 extraordinary circumstances, maternal health factors which demand termination of the pregnancy can
37 be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of
38 the fetus argues for ending the pregnancy by appropriate delivery. (BOT Rep. 26, A-97; Modified and
39 Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

40
41 *Policy H-5.997, “Violence Against Medical Facilities and Health Care Practitioners and Their*
42 *Families”*

43 The AMA supports the right of access to medical care and opposes (1) violence and all acts of
44 intimidation directed against physicians and other health care providers and their families and (2)
45 violence directed against medical facilities, including abortion clinics and family planning centers, as
46 an infringement of the individual's right of access to the services of such centers.

47 (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed:
48 CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

DISCUSSION

In its review of the policy compendium, the Board identified some duplicative policies. Policy H-5.993, “Right to Privacy in Termination of Pregnancy” and Policy H-5.995, “Abortion,” each contain nearly identical language affirming: (1) that abortion is a medical procedure that should be performed in conformance with standards of good medical practice and the laws of the state; (2) that no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles; and (3) that a physician or other professional who wishes to withdraw from a case must do so in conformance with good medical practice. Additionally, Policy H-5.983, “Pregnancy Termination,” Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and Policy H-5.995, “Abortion,” each state that abortions should be performed only by physicians. Accordingly, the AMA Board of Trustees (the Board) recommends that these policies (Policy H-5.993, “Pregnancy Termination,” Policy H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination”) be consolidated into one policy, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and that the remaining two policies be rescinded.

The Board also identified some policies that require updating or amendment for clarification purposes. Specifically, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” states that physicians may withdraw from cases they view as violative of good medical judgment or personally held moral principles so long as withdrawal is consistent with good medical practice. The Board recommends that this policy also state that withdrawal due to personally held moral principles must be consistent with ethical obligations. *AMA Code of Medical Ethics* Opinion 1.1.7, “Physician Exercise of Conscience,” states, among other things, that “physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.”

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that the AMA supports the position that “the early termination of pregnancy is a medical matter between the patient and the physician [...]” The Board notes that inclusion of the word “early” has created some confusion. Since Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” already addresses determinations of fetal viability and indications for abortion late in pregnancy, the Board recommends deletion of the word “early.”

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that an abortion should only be performed by a physician. This policy was adopted when most abortions were surgical; however, by 2020, an estimated 54% of abortions were induced with prescription medication. The Board recommends this policy be amended to state that abortion is “the practice of medicine and requires the personal performance or supervision by an appropriately licensed physician.” The amendment will enable the AMA to advocate for broad, equitable access to abortion care in accordance with Policy D-5.999, “Preserving Access to Reproductive Health Services,” by building capacity within the physician-led healthcare teams that provide abortion care, while also advocating for continued physician supervision of non-physicians who prescribe medication for abortions.

Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that abortion “is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.” The Board recommends replacing “availability of appropriate facilities” with “ability to perform the procedure safely.” Because over half of abortions are now induced with prescription medication, they do not necessarily require care in a facility. Conditioning AMA support of abortion care on “availability of appropriate facilities” may be used by some as justification for placing medically unnecessary facility requirements on abortion providers. By amending the policy to emphasize safety generally, the policy is less likely to be misconstrued.

1 In addition, Policy H-5.990, “Policy on Abortion,” states that support of or opposition to abortion is a
2 matter for members to decide individually. Since newly adopted policy at the 2022 Annual Meeting,
3 Policy D-5.999, “Preserving Access to Reproductive Health Services,” supports access to abortion as an
4 organizational policy matter, the Board recommends that Policy H-5.990, “Policy on Abortion,” be
5 amended to clarify that the AMA believes members’ *personal* views on abortion should be decided
6 individually.

7
8 Additionally, Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” states that the
9 determination of the viability of a fetus during the second trimester is to be made by a physician. Newly
10 adopted policy at the 2022 Annual Meeting, Policy D-5.999, “Preserving Access to Reproductive Health
11 Services,” is broader. Specifically, this new policy protects clinical determinations and assessments
12 regardless of the stage of pregnancy. The Board, therefore, recommends that Policy H-5.982, “Late-Term
13 Pregnancy Termination Techniques,” be amended to remove the reference to viability in the second
14 trimester. Policy H-5.982 also includes a recognition of the constitutional principles articulated by the
15 Supreme Court in *Roe v. Wade*. In light of the Supreme Court’s decision in *Dobbs v. Jackson Women’s*
16 *Health Organization*, the Board recommends that Policy H-5.982 be further amended to reflect this legal
17 activity.

18
19 Finally, with the completion of this report, the Board recommends that Policy D-5.999, “Preserving
20 Access to Reproductive Health Services,” be amended to remove the directive to review AMA policy,
21 recommend policies for amendment or rescission and report back at the 2022 Interim Meeting.

22
23 In addition to review of policy required by the new policy, the Board notes that Resolution 621-A-22,
24 Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based,
25 Appropriate Care Is Banned or Restricted, instructs our AMA to convene a task force to respond to
26 restrictions on and criminalization of abortion and other evidence-based care. Importantly, at the time of
27 the writing of this report (August 2022), the AMA is in the process of developing the task force, with the
28 task force expected to be formed by the time of the AMA 2022 Interim Meeting in November. It is critical
29 to further note that activity—in both AMA Advocacy and AMA Office of General Counsel—to protect
30 the patient-physician relationship is robust and ongoing. The following is a summary of relevant activity
31 as of early August 2022 when this report was drafted.

32
33 Since the U.S. Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization* which
34 overturned *Roe v. Wade* and *Planned Parenthood v. Casey*, the AMA has been pursuing multiple
35 strategies, at the state level, to address the broad spectrum of issues now facing physicians and patients.
36 Shortly after the decision was issued, the AMA convened state medical associations to understand state-
37 by-state dynamics and the concerns of physicians. The AMA has since held multiple meetings with state
38 medical associations and national medical specialty societies to understand the challenges facing
39 physicians and plan a coordinated strategy to protect access to care. The AMA Advocacy Resource
40 Center is working closely with the Federation to protect patients and physicians from legislative
41 intrusions into and criminalization of the practice of medicine. In many states, it is not clear how broadly
42 abortion restrictions will be interpreted, and confusion remains about how restrictions impact medically
43 necessary pregnancy terminations, prescribing of certain medications for reasons unrelated to pregnancy,
44 and the provision of other types of care. The AMA is working with the Federation and other stakeholders
45 to seek clarification from policymakers, as well as collecting information, producing resources, and
46 conducting legislative analyses to help states navigate this new regulatory scheme.

47
48 One way AMA Advocacy staff is collecting much-needed clinical information for states across the
49 country is by engaging expert physician members of the Board, Council on Legislation, and Council on
50 Medical Service. AMA Advocacy staff is also engaging attorneys in the American Society of Medical
51 Association Counsel to identify answers to legal questions raised in states across the country as legislation

1 and regulation is contemplated and introduced. The AMA Center for Health Equity is collaborating with
 2 the AMA Advocacy team, as well, working to identify impact on historically marginalized and
 3 minoritized communities and strategies related to health equity. Finally, at the 2022 AMA State
 4 Advocacy Roundtable, the AMA hosted an interactive discussion among Federation staff about the
 5 implications of the *Dobbs* decision and because of that discussion is working to create resources for the
 6 Federation. This activity is ongoing.

7
 8 At the federal level, the AMA immediately called for greater digital privacy for patients out of concern
 9 that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to
 10 enforce abortion restrictions. The AMA joined the American College of Obstetricians and Gynecologists
 11 (ACOG) in calling for the U.S. Food and Drug Administration to remove or modify the Risk Evaluation
 12 and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for
 13 mifepristone. The Biden Administration also reminded hospitals and health care providers of their
 14 obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act
 15 (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including
 16 abortion procedures and other treatments that may result in the termination of a pregnancy, and reminded
 17 pharmacies of their obligations related to prescription medications for reproductive health under federal
 18 civil rights laws.

19
 20 Finally, in the courts, the AMA has joined ACOG and the Society for Maternal-Fetal Medicine in amicus
 21 briefs around the country seeking to protect access to reproductive care and combat intrusion on the
 22 physician-patient relationship. As of early August, amicus briefs have been filed in Georgia, Kentucky,
 23 Ohio, South Carolina, Utah, and West Virginia. Additional filings are expected in coming months. These
 24 briefs have supported challenges to a range of harmful laws, including bans from the 1800s, trigger laws
 25 intended to ban all abortion following the reversal of *Roe v. Wade*, and criminal penalties that potentially
 26 include felony charges for physicians. In addition, the AMA has worked to support federal guidance and
 27 litigation around access to care in the courts through its amicus efforts. The AMA will continue to work
 28 with the Federation and external stakeholders in the courts and at the state and federal levels to protect the
 29 physician-patient relationship and access to reproductive care.

30 31 RECOMMENDATIONS

32
 33 The Board recommends that the following recommendations be adopted and that the remainder of the
 34 report be filed.

- 35
36 1. That Policy H-5.993, “Right to Privacy in Termination of Pregnancy” be amended by addition
37 and deletion as follows:

38
 39 The AMA reaffirms existing policy that (1) abortion is the practice of medicine and requires the
 40 personal performance or supervision by an appropriately licensed physician a medical procedure
 41 and should be performed only by a duly licensed physician in conformance with standards of
 42 good medical practice and the laws of the state; and (2) no physician or other professional
 43 personnel shall be required to perform an act violative of good medical judgment or personally
 44 held moral principles. In these circumstances good medical practice requires only that the a
 45 physician or other professional may withdraw from the case so long as the withdrawal is
 46 consistent with good medical practice and ethical guidance on the exercise of conscience;- (3)
 47 The AMA further supports the position that the early termination of pregnancy is a medical
 48 matter between the patient and the physician, subject to the physician's clinical judgment, the
 49 patient's informed consent, and the ability to perform the procedure safely-availability of
 50 appropriate facilities. (Modify Current HOD Policy)

2. That Policies H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination,” be rescinded. (Rescind HOD Policy)

3. That Policy H-5.990, “Policy on Abortion,” be amended by addition as follows:

The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. (Modify HOD Policy)

4. That Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” be amended by addition and deletion as follows:

(1) The term “partial birth abortion” is not a medical term. The AMA will use the term “intact dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA. (2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient. (3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. ~~In the second trimester w~~When viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology. (4) ~~In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and~~ In keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery. (Modify Current HOD Policy)

5. Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by deletion as follows:

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their

1 patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts
2 against patients, patient advocates, physicians, other healthcare workers, and health systems for
3 receiving, assisting in, referring patients to, or providing reproductive health services; (7) will
4 advocate for legal protections for patients who cross state lines to receive reproductive health
5 services, including contraception and abortion, or who receive medications for contraception and
6 abortion from across state lines, and legal protections for those that provide, support, or refer
7 patients to these services; and (8) will review the AMA policy compendium and recommend
8 policies which should be amended or rescinded to reflect these core values, with report back at
9 the 2022 Interim Meeting. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-22

Subject: Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

BACKGROUND

At the November 2020 House of Delegates (HOD) meeting, the [House of Delegates referred Resolution 602](#), “Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA.” [Resolution 602](#), introduced by the Women Physicians Section asked that our American Medical Association (AMA):

Adopt an overarching non-discrimination policy on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities that applies to members, employees and patients. (New HOD Policy)

Demonstrate its commitment to complying with laws, rules or regulations against discrimination on the basis of protected characteristics. (Directive to Take Action)

Reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040, “Principles on Corporate Relationships,” in its overarching non-discrimination policy. (Reaffirm HOD Policy)

Reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment.” (Reaffirm HOD Policy)

Study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy, and report back to the AMA House of Delegates within 18 months. (Directive to Take Action)

Provide an update on its comprehensive diversity and inclusion strategy to the AMA House of Delegates within 24 months. (Directive to Take Action)

Resolution 602 calls upon our AMA to adopt an overarching non-discrimination policy; reaffirm current AMA policy; study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy; and provide an update on our AMA’s comprehensive diversity and inclusion strategy.

The reference committee received testimony supportive of the intent of Resolution 602 but noted there were several amendments proffered to broaden inclusiveness, as well as to strengthen the

1 language contained in existing AMA policy. Still others advocated for referral of this item due to
2 the complexity of the requests and the need to develop an integrated response.

3
4 The reference committee supported referral of this item to allow our AMA House of Delegates to
5 receive a report back that codifies policies and activities and optimizes the language contained in
6 an overarching non-discrimination policy.

7
8 This report: 1) describes our AMA's commitment to human rights and health equity that would
9 support an overarching non-discrimination policy and 2) summarizes our AMA's existing non-
10 discrimination policies passed by the House of Delegates.

11 12 DISCUSSION

13
14 The federal landscape related to discrimination is constantly evolving, so any overarching policy
15 will need to be flexible in its wording and regularly updated.

16
17 The HOD's policy statements on health topics serve as a cornerstone of our AMA, making clear
18 what our AMA stands for as an organization, providing information and guidance to physicians and
19 others about health care issues.

20 21 *AMA's commitment to human rights and health equity*

22
23 Our AMA Policy H-65.965, "Support of Human Rights and Freedom," provides a clear statement
24 of our AMA's commitment to supporting and maintaining respect for human rights. It reads as
25 follows:

26
27 Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity
28 of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any
29 human being of equal rights, privileges and responsibilities commensurate with his or her
30 individual capabilities and ethical character because of an individual's sex, sexual orientation,
31 gender, gender identity or transgender status, race, religion, disability, ethnic origin, national
32 origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation,
33 gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and
34 any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat
35 to the public health and social welfare of the citizens of the United States, urges expedient
36 passage for appropriate hate crimes prevention legislation in accordance with our AMA's
37 policy through letters to members of Congress; and registers support for hate crimes prevention
38 legislation, via letter, to the President of the United States.

39
40 The policy provides a key foundation in fostering equity and inclusion both within the organization
41 and externally.

42
43 Additionally, our AMA has [made a commitment](#) to "actively work to dismantle racist and
44 discriminatory policies and practices across all of health care." Furthermore, "our AMA recognizes
45 that racism in its systemic, structural, institutional, and interpersonal forms as a serious threat to
46 public health, the advancement of health equity, and a barrier to appropriate medical care" and
47 "supports the development of policy to combat racism and its effects" (Policy H-65.952, "Racism
48 as a Public Health Threat").

49
50 By establishing the AMA Center for Health Equity, our AMA has demonstrated its intention and
51 commitment to [embed health equity into the DNA of the organization](#) and its work. As part of the

“Plan for Continued Progress Toward Health Equity” (Policy D-180.981) our AMA has made the pursuit of diversity, equity, and inclusion a key strategy to operationalize health equity. This pursuit includes a commitment to anti-racism/anti-discrimination/anti-harassment policies. Our AMA has continued to expand on our diversity and inclusion strategy as outlined in Board Report 10-A-22 about 2021 progress on the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity.

Existing AMA HOD non-discrimination policies

A policy scan of our AMA’s HOD non-discrimination policies identified 88 non-discrimination policies. This summary only includes policies currently published in our AMA’s PolicyFinder. Policies that were rescinded are not included. The policies are grouped below based on the nature of the protections covered by the policies. The number of policies matched to each grouping is listed below (Please see Appendix A for details):

- Non-discrimination policies – AMA (3)
- Non-discrimination policies – Constitution and Bylaws (3)
- Non-discrimination policies listed under AMA governance (3)
- General non-discrimination policies that protect all individuals (11)
- Non-discrimination policies that apply to specific populations (17)
- Non-discrimination policies that protect physicians and/or their practices (23)
- Non-discrimination policies that protect international medical graduates (IMGs) (4)
- Non-discrimination policies that protect residents (5)
- Non-discrimination policies that protect medical students (4)
- Non-discrimination policies that protect patients (14)
- Non-discrimination related to terrorism (1)

Within HOD policies, H-65.965, “Support of Human Rights and Freedom,” modified in 2022, provides the most comprehensive list of protected groups. Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” mentioned in the original resolution, was rescinded and replaced [via Board Report 5-N-21](#) by Policy H-65.950 stating that our AMA recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements. Board Report 5-N-21 provides a summary of categories or characteristics cited by AMA policy and a sampling from other organizations.

Policy H-65.951, “Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions,” provides guidelines for effective non-discrimination policy for healthcare, including implementation considerations.

Eight other HOD policies provide a similar list of protections, 17 policies target discrimination of very specific groups (e.g., victims of domestic violence), and seven policies used the word “discrimination” in the title of the policy but not within the body of the policy statement.

Policy H-140.837, “Policy on Conduct at AMA Meetings,” sets forth our AMA’s policy of zero tolerance for any type of harassing conduct by physicians and others attending AMA functions or meetings and defines prohibited behaviors. The policy also provides multiple reporting options available to both the targets of any harassment and witnesses to prohibited conduct, including an option to register complaints confidentially to an external vendor online or via a toll-free hotline.

1 Multiple HOD policies seek to influence the non-discrimination policies and/or activities of other
2 organizations. In some (but not all) instances, the policies are membership related. Non-
3 discrimination policies related to membership include: G-600.020, "Admission of Specialty
4 Organizations to our AMA House," and G-600.014, "Guidelines for Admission of Constituent
5 Associations to our AMA House of Delegates." Policies unrelated to membership include:
6 D-255.995, "Discrimination Against IMGs in Classified Advertising," and H-295.955, "Teacher-
7 Learner Relationship in Medical Education."

8
9 Policy H-65.988, "Organizations Which Discriminate," also listed as a relevant AMA policy in
10 Resolution 602, provides the organization with guidance encouraging, but not mandating, that
11 meetings or other gatherings be held in organizational facilities that do not discriminate on the
12 basis of race, religion, or gender and encourages its constituent societies to adopt a similar policy.
13

14 RECOMMENDATIONS

15
16 Based on a review of internal policies, the Board of Trustees recommends that the following
17 recommendations be adopted in lieu of Resolution 602-N-20, and the remainder of this report be
18 filed.
19

- 20 • That our AMA reaffirm its commitment to complying with all applicable laws, rules or
21 regulations against discrimination on the basis of protected characteristics, including Title
22 VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the
23 Americans with Disabilities Act, among other federal, state and local laws. (New HOD
24 Policy)
- 25 • That our AMA reaffirm Policy H-65.965, "Support of Human Rights and Freedom," as an
26 overarching non-discrimination policy for the Association. (Reaffirm HOD Policy)
- 27 • That our AMA reaffirm Policy H-65.988, "Organizations Which Discriminate," Policy G-
28 630.040, "Principles on Corporate Relationships," and Policy H-65.950, "Terms and
29 Language in Policies Adopted to Protect Populations from Discrimination and
30 Harassment." (Reaffirm HOD Policy)
- 31 • That our AMA provide updates on its comprehensive diversity and inclusion strategy as
32 part of the annual Board report to the AMA House of Delegates on health equity.
33 (Directive to Take Action)

Fiscal Note: Within current budget

APPENDIX A: AMA Non-Discrimination Policies

Note: This summary only includes policies currently published in our AMA's PolicyFinder. Policies that were rescinded are not included.

Non-discrimination policies – AMA (3)

- [Policy on Conduct at AMA Meetings and Events H-140.837](#)
- [Non-discrimination Policy H-65.983](#)
- [Organizations Which Discriminate H-65.988](#)

Non-discrimination policies – Constitution and Bylaws (3)

- [Discrimination. B-1.4](#)
- [Resident and Fellow Section. B-7.1.4 Other Representatives to the Business Meeting](#)
- [Medical Student Section. B-7.3.3.4 National Medical Student Organizations.](#)

Non-discrimination policies listed under governance (3)

- [Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment H-65.950](#)
- [Admission of Specialty Organizations to our AMA House G-600.020](#)
- [Guidelines for Admission of Constituent Associations to our AMA House of Delegates G-600.014](#)

General non-discrimination policies that could potentially apply to/benefit all individuals: (11)

- [Support of Human Rights and Freedom H-65.965](#)
- [Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984](#)
- [Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951](#)
- [Code of Medical Ethics 7.3.7 Safeguards in the Use of DNA Databanks](#)
- [Issues in Employee Drug Testing H-95.984](#)
- [Code of Medical Ethics 4.1.3 Third-Party Access to Genetic Information](#)
- [Code of Medical Ethics 11.1.1 Defining Basic Health Care](#)
- [Individual Health Insurance H-165.920](#)
- [Code of Medical Ethics 9.5.3 Accreditation](#)
- [Discriminatory Policies that Create Inequities in Health Care H-65.963](#)
- [Code of Medical Ethics 4.2.6 Cloning for Reproduction](#)

Non-discrimination policies that apply to specific populations (17)

- [Federal Drug Policy in the United States H-95.981](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976](#)
- [Insurance Discrimination Against Victims of Domestic Violence H-185.976](#)
- [Racial and Ethnic Disparities in Health Care H-350.974](#)
- [Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917](#)
- [Retirement and Hiring Practices H-25.996](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations D-65.996](#)
- [Health Care Disparities in Same-Sex Partner Households H-65.973](#)
- [Code of Medical Ethics 4.2.1 Assisted Reproductive Technology](#)
- [Code of Medical Ethics 4.2.3 Therapeutic Donor Insemination](#)

- [Removing Financial Barriers to Living Organ Donation H-370.965](#)
- [Organ Transplant Equity for Persons with Disabilities D-370.980](#)
- [Ensuring the Best In-School Care for Children with Diabetes H-60.932](#)
- [Improving Screening and Treatment Guidelines for Intimate Partner Violence \(IPV\) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals \(LGBTQ\) D-515.980](#)
- [Juvenile Justice System Reform H-60.919](#)
- [Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951](#)
- [Parental Leave H-405.954](#)

Non-discrimination policies that protect physicians and/or their practices (23)

- [Advocacy for Physicians with Disabilities D-90.991](#)
- [Principles for Advancing Gender Equity in Medicine H-65.961](#)
- [Code of Medical Ethics 9.5.5 Gender Discrimination in Medicine](#)
- [Women in Organized Medicine H-525.998](#)
- [Volume Discrimination Against Physicians H-180.963](#)
- [Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986 H-390.962](#)
- [Discrimination of Women Physicians in Hospital Locker Facilities H-525.981](#)
- [Discrimination Against Physicians by Health Care Plans H-285.985](#)
- [Amend the Patient Protection and Affordable Care Act \(PPACA\) H-165.833](#)
- [Redefining AMA's Position on ACA and Healthcare Reform D-165.938](#)
- [Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws H-35.968](#)
- [Protection of Medical Staff Members' Personal Proprietary Financial Information H-225.955](#)
- [PRO Readmission Review H-340.989](#)
- [Medical Specialty Board Certification Standards H-275.926](#)
- [Intrusion by Hospitals into the Private Practice of Medicine H-240.979](#)
- [Equal Payment for Services H-385.945](#)
- [Hospitals Limited to Participating Physicians H-390.971](#)
- [Code of Medical Ethics 5.7 Physician-Assisted Suicide](#)
- [AMA Principles for Physician Employment H-225.950](#)
- [Limitation of Physicians' Fees H-380.997](#)
- [Patient Protection and Clinical Privileges H-230.989](#)
- [Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders \(MOUD\) H-95.913](#)
- [Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949](#)

Non-discrimination policies that protect IMGs (4)

- [Unfair Discrimination Against International Medical Graduates H-255.978](#)
- [AMA Principles on International Medical Graduates H-255.988](#)
- [Abolish Discrimination in Licensure of IMGs H-255.966](#)
- [Discrimination Against IMGs in Classified Advertising D-255.995](#)

Non-discrimination policies that protect residents (5)

- [Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919](#)
- [Eliminating Religious Discrimination from Residency Programs H-310.923](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)
- [Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971](#)
- [Non-discrimination Toward Residency Applicants H-295.969](#)

Non-discrimination policies that protect medical students (4)

- [Equal Fees for Osteopathic and Allopathic Medical Students H-295.876](#)
- [Underrepresented Student Access to US Medical Schools H-350.960](#)
- [Teacher-Learner Relationship In Medical Education H-295.955](#)
- [Principles of and Actions to Address Primary Care Workforce H-200.949](#)

Non-discrimination policies that protect patients (14)

- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act D-185.981](#)
- [Genetic Discrimination and the Genetic Information Non-discrimination Act H-65.969](#)
- [Consumer Genetic Testing and Privacy D-315.970](#)
- [Discrimination and Criminalization Based on HIV Seropositivity H-20.914](#)
- [Patient Privacy and Confidentiality H-315.983](#)
- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925](#)
- [Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders H-345.986](#)
- [Non-discrimination in Health Care Benefits H-185.986](#)
- [Gender Rating and Discrimination Based on Prior Cesarean Section H-180.950](#)
- [Discrimination Against Patients by Medical Students H-295.865](#)
- [Discriminatory Payment Policies D-70.969](#)
- [The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987](#)
- [Code of Medical Ethics 1.1.7 Physician Exercise of Conscience](#)
- [Assistants at Surgery H-385.969](#)

Non-discrimination related to terrorism (1)

- [Non-discrimination in Responding to Terrorism H-65.978](#)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-22

Subject: Terms and Language in Policies Adopted to Protect Populations from
Discrimination and Harassment

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

BACKGROUND

At the November 2021 Special Meeting of the House of Delegates (HOD), the HOD adopted Policy H-65.950, which reads as follows:

Our AMA recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

This report: 1) summarizes key points and findings of Board of Trustees Report 5-N-21, updates from other policies adopted by our AMA in 2021, relevant information from the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity ("Strategic Plan") and the AMA-AAMC Advancing Health Equity: A Guide to Language, Narrative and Concepts, and feedback from stakeholders ("Narrative Guide"); and 2) recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

DISCUSSION

Language matters especially in medicine. How physicians transcribe and communicate about healthcare with other healthcare workers and with patients adds context and framing to any discussion. The significance of language is even more critical when it concerns sensitive topics, including those involving race, ethnicity, gender, sexual orientation, and gender identity and how their use, misuse, or non-use impact care. Engaging in such discussions within medicine provides a chance to not only showcase language's fluidity in action, essentially the manner in which terms and/or phrases evolve as individuals and groups decide on new ways to identify themselves, but to also advance health equity. Equity work within healthcare requires acknowledging and reconsidering one's beliefs about health, healthcare, health systems and society. Related to this is the consideration of the language and narratives that consistently contribute to our thoughts and actions.

Language and identity often go together and are critical within health equity. Both are fluid and most importantly, social constructs, meaning they are derived from humans and can change as time progresses. For example, the acronym BIPOC is used to collectively refer to those who identify as Black, Indigenous, and People of Color; it was created within the last decade. Some view it as a shift away from using other terms such as "marginalized" and "minority" and is another term used to unify and amplify communities that have long been shunned and/or ignored. However, there are others that have differing opinions. Jonathan Rosa, sociocultural and linguistic anthropologist, and associate professor at Stanford University explains that BIPOC "presupposes a kind of solidarity

and a shared positionality that doesn't play out in practice for a lot of people, and in fact obscures more than it reveals from some perspectives." It can also have an impact on research. Some scholars have argued that aggregating data can mask critical in-group differences and disparities, limiting efforts to specifically target resources. AMA has acknowledged this in recent years through the adoption of Policy D-350.979 at the 2021 Interim Meeting directing the organization to add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. Therefore, the acronym can be used in certain circumstances, but should not be used in quantitative reporting to unnecessarily aggregate groups; instead, disaggregated data should be used to depict the experiences of groups (see AMA AAPI Data [Report](#)).

Additional key terms to consider such as sex and gender are often mistakenly used interchangeably. Within medicine, sex or "sex assigned at birth" is a label typically given by a physician based on the genitals a person is born with, but over time that very label may not align with how they identify. According to *The Oxford Handbook of Gender and Politics*, gender, refers to the social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither. The American Academy of Pediatrics defines gender identity as "one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, ... a combination of both, or neither (i.e., not conforming to a binary conceptualization of gender)."

Language usage is critical. At a time when so many are working to not only diversify medicine, but promote antiracism, the terms and phrases that are amplified can have lasting impacts that can cause harm for both physicians and patients.

Board Report 5-N-21 notes: "Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S." The landscape related to protected personal characteristics is constantly evolving (e.g., update to Title IX), so any recommendation on terminology will need to be flexible in its wording and regularly updated to remain in compliance.

Board of Trustees Report 5-N-21 also found protected personal characteristics mentioned in existing policy of the AMA and other organizations at frequencies detailed in Appendix A, with minor adjustments made accounting for additional policy adopted by the AMA since the report was adopted (e.g., Policy H-350.960, Underrepresented Student Access to US Medical Schools).

Finally, while not policy, the Strategic Plan and the Narrative Guide offer language (see Appendices B and C). The Strategic Plan at various points (see pages 11-16) mentions: "race, ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical Graduates)," "gender, gender identity, sexual orientation, disability, age, class/socioeconomic status, citizenship status and language," "marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians," "race/ethnicity, gender, sexual identity, immigration status, country of origin, language and disability status," and "race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy." The Narrative Guide at various points (see pages 9-15) mentions: "formerly incarcerated/returning citizen/persons with a history of incarceration," "sex assigned at birth," and "ethnicity, nationality, class, or other status/identities." The Narrative Guide stresses the importance of avoiding "dehumanizing language" and instead "offering equity-based, equity

explicit, and person-first alternatives” and advises us to “describe people as having a condition or circumstance, not being a condition” and “humanize those you are referring to by using people or persons.” Person-first or people-first formulations include: “people with...,” “people experiencing...,” and “people identifying as...” However, the Narrative Guide notes that “different communities and individuals have different standards and preferences” regarding person-first language.

RECOMMENDATION

Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That our AMA amend Policy H-65.950 by addition and deletion to read as follows:

Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA recommends acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for Inclusive Communication ~~to~~ that may be used in AMA policies and position statements.
(Modify Current HOD Policy)

Fiscal Note: Less than \$500

APPENDIX A: Terminology Used in Existing Policy from AMA and Other Organizations

Characteristic	Federal Agencies (DOE, EEOC, HHS)	AMA Policy	Other Professional Societies (Convenience Sample)	Schools (Convenience Sample)
Affiliational preferences				1
Age	3	10	8	10
Ancestry			2	4
Appearance			1	1
Body habitus			1	
Citizenship		1	1	1
Color	3	4	7	10
Country of education or origin		1		
Creed		3	1	4
Culture		1		
Degree of medical dependency		1		
Dependent status				
Disability	3	8	10	10
Disability, present or predicted		1		
Drug abuse		1		
Economic		1		
Education			1	
Employment status				
Ethnic origin		5	8	3
Ethnicity		1		
Expected length of life		1		
Family status / responsibilities				1
Future plans for marriage or children		1		
Gender		7	7	2
Gender expression		2	3	3
Gender identity	1	10	7	10
Genetic information	1	3	1	8
Health / health status		1	1	
Immigration status			2	
International medical graduate		2		
Language preference			2	
Living donor status		1		
Marital status		4	2	4
Matriculation				1

Medical condition			1	2
Military/veteran status			5	10
National origin	3	7	8	10
Order of protection status				1
Other		4		1
Other legally protected basis				1
Other basis prohibited by law			2	
Other human condition or choice			1	
Other personal category			1	
Other protected group / category / characteristic			2	3
Other social category			1	
Participation in a PHP		1		
Political opinion / affiliation			1	1
Pregnancy	1		1	5
Professional experience			1	
Professional experience / profession		1		
Quality of life		1		
Race	3	11	12	10
Religion	1	8	11	10
Rurality		1		
Sex	3	9	5	10
Sexual orientation	1	10	11	10
Social status or condition			1	
Socioeconomic status			4	
Socioeconomic origin		1		
Unemployed status				1
Zip code			2	

APPENDIX B: Definitions and Levels of Racism sand Related Terms

	Definitions	Notes
Racism	As defined by Camara Jones, MD, MPH, PhD, "racism is a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources."	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term "prejudice" also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

	Definitions	Notes
Bias	<p>A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings.</p> <p>There are two main types of biases²⁰ discussed in scholarly research and in medicine^{21,22} that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> 1. Explicit or Conscious bias—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. Implicit or Unconscious bias—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society. 	<p>It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.</p>

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

APPENDIX C: Key Principles and Associated Terms

Table 1: Key Principles and Associated Terms

Key principles	Instead of this ...	Try this ...
<p>Avoid use of adjectives such as vulnerable, marginalized and high-risk.</p> <p>These terms can be stigmatizing. These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Try to use terms and language that explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).</p>	<ul style="list-style-type: none"> • Vulnerable groups • Marginalized communities • Hard-to-reach communities • Underserved communities • Underprivileged communities • Disadvantaged groups • High-risk groups • At-risk groups • High-burden groups 	<ul style="list-style-type: none"> • Groups that have been economically/ socially marginalized • Groups that have been historically marginalized or made vulnerable; <i>historically</i> marginalized • Groups that are struggling against economic marginalization • Communities that are underserved by/with limited access to (specific service/resource) • Under-resourced communities • Groups experiencing disadvantage because of (reason) • Groups placed at increased risk/put at increased risk of (outcome) • Groups with higher risk of (outcome) • For scientific publications: <ul style="list-style-type: none"> – Disproportionately affected groups – Groups experiencing disproportionate prevalence/rates of (condition)
<p>Avoid dehumanizing language. Use person-first language instead.</p> <p>Describe people as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving health care. Humanize those you are referring to by using people or persons.</p>	<ul style="list-style-type: none"> • The obese or the morbidly obese • COVID-19 cases • The homeless • Disabled person • Handicapped • Inmates • Victims • Cases or subjects (when referring to affected persons) • Individuals 	<ul style="list-style-type: none"> • People experiencing (health outcome or life circumstance) • People with obesity; people with severe obesity • Patients or persons with COVID-19 • People who are experiencing (condition or disability type) • Person with mobility disability • Person with vision impairments • People who are experiencing homelessness • Survivors
<p>Remember that there are many types of subpopulations.</p> <p>General use of the term minority/ minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).</p>	<ul style="list-style-type: none"> • Minorities • Minority • Ethnic groups • Racial groups 	<ul style="list-style-type: none"> • Specify the type of subpopulation: <ul style="list-style-type: none"> – (People from) racial and ethnic groups – (People from) racial and ethnic minority groups – (People from) sexual/gender /linguistic/religious minority groups – (People with/living with) mobility/ cognitive/vision/hearing/independent living/self-care disabilities
<p>Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities.</p> <p>These terms should also be avoided, in general, when communicating about public health activities.</p>	<ul style="list-style-type: none"> • Target communities for interventions • Target population • Tackle issues within the community • Aimed at communities • Combat (disease) • War against (disease) 	<ul style="list-style-type: none"> • Engage/prioritize/collaborate with/serve (population of focus) • Consider the needs of/Tailor to the needs of (population of focus) • Communities/populations of focus • Intended audience • Eliminate (issue/disease)
<p>Avoid unintentional blaming.</p> <p>Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances.</p>	<ul style="list-style-type: none"> • Workers who do not use PPE • People who do not seek healthcare 	<ul style="list-style-type: none"> • People with limited access to (specific service/resource) • Workers under-resourced with (specific service/resource)

Adapted from: "Health Equity Guiding Principles for Unbiased, Inclusive Communication" (CDC).

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-22

Subject: Updated Bylaws: Delegate Apportionment and Pending Members

Presented by: Kevin C. Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

At the 2022 Annual Meeting, the House adopted Recommendation 3 of BOT Report 20, “Delegate Apportionment and Pending Members,” in lieu of Resolution 618. This recommendation directs “That delegates be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:

- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than 5 delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5.”

Existing bylaw language on apportionment will sunset as of the close of business of the 2022 Interim Meeting; thus, the Council puts forth amended language consistent with the adopted recommendation of BOT Report 20-A-22. In doing so, the Council acknowledges that the Board’s actions on the other five referred recommendations in Board Report 20 may impact the House’s action on apportionment, if not for 2023 but for future years. The Board’s report on the referred items is also before the House at this meeting.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.1 Constituent Associations. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.4-2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

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

2.1.1.1 ~~The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. For 2023 only, the apportionment shall include the greatest of the following numbers: the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members consistent with Bylaw 2.1.1; the number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or for societies that would lose more than 5 delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5. Bylaw 2.1.1.1 will sunset as of December 31, 2023 the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.~~

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

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

2.1.1.2.1.1 ~~A constituent association that shows a membership loss for 2020 and/or 2021 shall be granted an additional one year grace period beyond the one year grace period set forth in 2.1.1.2.1 without a decrease in the number of delegates. This Bylaw will sunset at the close of the 2022 Interim Meeting. A constituent society may not benefit from both this provision and 2.1.1.1. Bylaw 2.1.1.2.1.1 will sunset as of December 31, 2023.~~

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1-2.1 using methods specified in AMA policy.

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 1-I-22

Subject: Amendment to Opinion 4.2.7, “Abortion”

Presented by: Peter A Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Current guidance on abortion in Opinion 4.2.7 of the AMA *Code of Medical Ethics* was issued in
2 1977 in the context of the U.S. Supreme Court decision in *Roe v. Wade*,¹ which recognized a
3 constitutional right to abortion. The Court’s recent decision in *Dobbs v. Jackson Women’s Health*
4 *Organization*² overturning *Roe* and returning debate about abortion to the states has significantly
5 altered the landscape for patients and their physicians.

6
7 As the American Medical Association immediately [noted](#), *Dobbs*:

8
9 overturn[s] nearly a half century of precedent protecting patients’ right to critical reproductive
10 health care—representing an egregious allowance of government intrusion into the medical
11 examination room, a direct attack on the practice of medicine and the patient-physician
12 relationship, and a brazen violation of patients’ rights to evidence-based reproductive health
13 services.

14
15 The AMA joined the American College of Obstetricians and Gynecologists and more than 70 other
16 professional medical associations in [condemning](#) the unacceptable effects *Dobbs* will have on
17 access to safe, accepted, essential reproductive health services; the privacy and integrity of patient-
18 physician relationships; and indeed, the safety of patients and physicians.

19
20 Guidance throughout the *Code* underscores physicians’ duty of fidelity to patients and to promote
21 access to care, as well as responsibility to support informed decision making in keeping with
22 patients’ individual goals and preferences as autonomous moral agents. The *Code* likewise
23 prohibits physicians acting as agents of government entities in conflict with their duties to patients.
24 At the same time, the *Code* acknowledges that physicians too are moral agents as individuals,
25 whose deeply held personal beliefs may at times conflict with the expectations held of them as
26 medical professionals, and offers guidance to help physicians navigate an ethically acceptable path
27 forward in the face of diverging commitments.

28
29 Finally, the *Code* [acknowledges](#) that although deeply intertwined, law and the ethical commitments
30 of the profession do not always align:

31
32 In some cases, the law mandates conduct that is ethically unacceptable. When physicians
33 believe a law violates ethical values or is unjust they should work to change in law. In
34 exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.

35
36 When the letter of the law would foreclose urgently needed care physicians must have latitude to
37 act in accord with their best professional judgement.

1 RECOMMENDATION

2
3 With all of the foregoing considerations in mind, the Council on Ethical and Judicial Affairs
4 recommends that Opinion 4.2.7, "Abortion," be amended as follows and the remainder of this
5 report be filed:

6
7 Abortion is a safe and common medical procedure, about which thoughtful individuals hold
8 diverging, yet equally deeply held and well-considered perspectives. Like all health care
9 decisions, a decision to terminate a pregnancy should be made privately within the relationship
10 of trust between patient and physician in keeping with the patient's unique values and needs
11 and the physician's best professional judgment.

12
13 The *Principles of Medical Ethics* of the AMA ~~do not prohibit a physician from performing an~~
14 ~~abortion~~ permit physicians to perform abortions in keeping with good medical practice ~~under~~
15 ~~circumstances that do not violate the law.~~
16 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

¹ *Roe v. Wade*, 410 U. S. 113 (1973).

² *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-22

Subject: Amendment to Opinion 10.8, “Collaborative Care”

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, as part of an effort to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as “Doctor of Nursing.” Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner’s skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term “nonphysician practitioners” denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are “multiple pathways” for one to become a nonphysician practitioner, the most common is a nurse earning a “master’s degree or doctoral degree in nursing” after initial completion of a bachelor’s degree [1]. However, the skill sets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as “Doctor” consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggest that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

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of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in “recent years, an explosion of doctorates in various medical professions has made the label of ‘doctor’ far less clear”, a common example being that of the “Doctor of Nursing Practice” (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a “political maneuver, designed to appropriate the title of ‘doctor’ and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public” [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be “addressed as ‘doctor’ if the DNP clarifies that he or she is actually an NP” and some jurisdictions require NPs without a doctorate to have special identification that “unambiguously identifies them” [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians, to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient’s autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient’s decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner’s skill set, education, and experience.

GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

House Policy

[H-405.992](#) – “Doctor as Title,” states:

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title ““Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

[D-405.991](#) – “Clarification of the Title “Doctor” in the Hospital Environment,” states:

Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

[H-405.969](#) – “Definition of a Physician”, states:

... a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the AMA definition above, must specifically and simultaneously declare themselves a “nonphysician” and define the nature of their doctorate degree.

Code of Medical Ethics

The Code already addresses transparency in context of residents and fellows. [Opinion 9.2.2](#), “Resident & Fellow Physicians’ Involvement in Patient Care,” possesses some language regarding transparency and identification where it states:

When they are involved in patient care, residents and fellows should:

(a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, [Opinion 10.8](#), “Collaborative Care” is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

RECCOMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician relationship~~, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient’s care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

- (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
- (ii) Clearly articulating individual responsibilities and accountability
- (iii) Encouraging insights from other members and being open to adopting them and
- (iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, ~~and~~ respecting their unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

(~~f~~g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(~~g~~h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(~~h~~i) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Government Accountability Office. *Healthcare Workforce: Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants*, 2019. Available at: <https://www.gao.gov/assets/710/703372.pdf?fbclid=IwAR1-3D5tOArzcS6lLRkMDT6wIksFyX3-yaw75SXOSP55YgOlun4SyBhZhEQ>. Accessed March 5, 2022.
2. American Medical Association. *Truth in Advertising Survey*, 2018. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf. Accessed March 5, 2022.
3. Al-Agba N & Bernard R. *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Irvine, CA: Universal Publishers, 2020.
4. Lindell D, Hagler D, Poindexter K. PhD or DNP? Defining the Path to Your Career Destination. *American Nurses Today*. 2017;12(2):36-39.
5. Zand MB. Nursing the primary care shortage back to health: how expanding nurse practitioners autonomy can safely and economically meet the growing demand for basic health care. *J. Law & Health*. 2011;24(2):261-284.

Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy D-130.960, “Pandemic Ethics and the Duty of Care,” adopted by the American Medical
2 Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial
3 Affairs (CEJA) to “reconsider its guidance on pandemics, disaster response and preparedness in
4 terms of the limits of professional duty of individual physicians, especially in light of the unique
5 dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.”
6

7 At the 2022 Annual Meeting, the Council’s informational report on this matter, CEJA Report 5-A-
8 22, was extracted and referred to Reference Committee on Amendments to Constitution and
9 Bylaws. Testimony acknowledged that the Council has disseminated interpretive materials to help
10 users apply guidance from multiple Opinions in the AMA *Code of Medical Ethics* relating to the
11 duty to treat in crisis situations but felt that additional guidance was nonetheless needed in the
12 *Code* itself. The present report proposes amendments to Opinion 8.3, “Physician Responsibility in
13 Disaster Response and Preparedness.”
14

15 A CONTESTED DUTY

16
17 As several scholars have noted, the idea that physicians have a professional duty to treat has waxed
18 and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled
19 the Black Death; those who remained did so out of religious devotion, or because they were enticed
20 by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians
21 contested whether they had a responsibility to put themselves at risk for what was then a lethal and
22 poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in
23 1847 codified a clear expectation that physicians would accept risk:
24

25 When pestilence prevails, it is [physicians’] duty to face the danger, and to continue their
26 labors for the alleviation of suffering, even at the jeopardy of their own lives [[1847 Code](#), p.
27 105].
28

29 That same sensibility informs AMA’s [Declaration of Professional Responsibility](#) when it calls on
30 physicians to “apply our knowledge and skills when needed, though it may put us at risk.” And it is
31 embedded in current guidance in the *Code*. Based on physicians’ commitment of fidelity to
32 patients, [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness,”
33 enjoins a duty to treat. This opinion provides that “individual physicians have an obligation to
34 provide urgent medical care during disasters . . . even in the face of greater than usual risks to

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physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute, however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future."

From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat but how to think about the relative strength of that duty in varying circumstances.

INTERPRETING ETHICS GUIDANCE

Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat [unvaccinated patients](#) and under what conditions medical students may ethically be permitted to [graduate early](#) to join the physician workforce.

Drawing particularly on guidance in [Opinion 1.1.2](#), "Prospective Patients," and—in keeping with Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—[Opinion 11.1.3](#), "Allocating Limited Health Care Resources," as well as [Opinion 8.7](#), "Routine Universal Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty to treat:

- urgency of medical need
- risk to other patients or staff in a physician's practice
- risk to the physician
- likelihood of occurrence and magnitude of risk

To these criteria should be added likelihood of benefit—that is, physicians should not be obligated to put themselves at significant risk when patients are not likely to benefit from care [2]. Although the *Code* does not link the question specifically to situations of infectious disease or risk to physicians, it supports this position. [Opinion 5.5](#), "Medically Ineffective Interventions," provides that physicians are not obligated to provide care that, in their considered professional judgment, will not provide the intended clinical benefit or achieve the patient's goals for care.

Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to protect the well-being of patients and staff, it supports consideration of risk to others in assessing the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians from declining a patient based solely on the individual's disease status, it permits them to decline to provide care to patients who threaten the well-being of other patients or staff. In the context of a serious, highly transmissible disease this responsibility to minimize risk to others in professional settings may constrain the presumption of a duty to treat.

Yet the *Code* is also silent on important matters that have been noted in the literature. For example, it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some scholars argue that the obligation should be understood as conditioned by physicians' expertise, training, and role in the health care institution [4,5,6]. In essence, the argument is that the more relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to expect physicians to accept greater personal risk than clinicians who do not have the same expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the exclusive province of any individual health profession" [2], risks undercutting its own value to offer insight into that duty.

Moreover, for the most part the *Code* restricts its analysis of physicians' responsibilities to the context of their professional lives, addressing their duties to patients, and to a lesser degree, to their immediate colleagues in health care settings. In this, guidance overlooks the implications of responsibilities physicians hold in their *nonprofessional* lives—as members of families, as friends, as participants in community outside the professional domain. Thus, it is argued, a physician whose household includes a particularly vulnerable individual—e.g., someone who has chronic underlying medical condition or is immune compromised and thus at high risk for severe disease—has a less stringent duty to treat than does a physician whose personal situation is different.

Although the *Code* acknowledges that physicians indeed have lives as moral agents outside medicine ([Opinion 1.1.7](#), “Physician Exercise of Conscience”), it does not reflect as deeply as it might about the nature of competing personal obligations or how to balance the professional and the personal. In much the same way as understanding the duty to treat as the responsibility of a single profession, restricting analysis to a tension between altruism and physicians' individual self-interests “fails to capture the real moral dilemmas faced by health care workers in an infectious epidemic” [7].

SUPPORTING THE HEALTH CARE WORKFORCE

As adopted in 1847, the *Code* addressed physicians' ethical obligations in the broader framework of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code* came to focus primarily on physician conduct.

Pandemic disease doesn't respect conceptual boundaries between the professional and the personal, the individual and the institutional. Nor does it respect the borders of communities or catchment areas. In situations of pandemic disease, “the question is one of a social distribution of a biologically given risk within the workplace and society at large” [7].

Health Care Institutions

Under such conditions, it is argued, the duty to treat “is not to be borne solely by the altruism and heroism of individual health care workers” [7]. Moreover, as has been noted,

... organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on institutions' responsibility to the communities they serve ([Opinion 11.2.6](#), “Mergers between Secular and Religiously Affiliated Health Care Institutions”) and the needs of physicians and other health care personnel who staff them ([Opinions 11.1.2](#), “Physician Stewardship of Health Care Resources,” and [11.2.1](#), “Professionalism in Health Care Systems”). Health care facilities and institutions are the locus within which the practice of today's complex health care takes place. As such, institutions—notably nonprofit institutions—too have duties,

... fidelity to patients, service to patients, ensuring that the care is high quality and provided “in an effective and ethically appropriate manner”; service to the community the hospital serves, deploying hospital resources “in ways that enhance the health and quality of life” of the community; and institutional stewardship [[CEJA 2-A-18](#)].

Analyses posted to the AMA's COVID-19 Resource Center look to this guidance to examine institutional obligations to [protect health care personnel](#) and to respect physicians who voice concern when institutional [policies and practices](#) impinge on clinicians' ability to fulfill their ethical duties as health care professionals.

Although existing guidance does not explicitly set out institutional responsibility to provide appropriate resources and strategies to mitigate risk for health care personnel, it does support such a duty. The obligation to be responsible stewards of resources falls on health care institutions as well as individuals. To the extent that health care professionals themselves are an essential and irreplaceable resource for meeting patient and community needs, institutions have an ethical duty to protect the workforce (independent of occupational health and safety regulation). On this view, institutions discharge their obligations to the workforce when, for example, they:

- support robust patient safety and infection control practices
- make immunization readily available to health care personnel
- provide adequate supplies of appropriate personal protective equipment (PPE)
- ensure that staffing patterns take into account the toll that patient care can exact on frontline clinicians
- distribute burdens equitably among providers in situations when individual physicians or other health care personnel *should not* put themselves at risk
- have in place fair and transparent mechanisms for responding to individuals who decline to treat on the basis of risk. (Compare Opinion 8.7, "Routine Universal Immunization of Physicians.")

Equally, institutions support staff by gratefully acknowledging the contributions all personnel make to the operation of the institution and providing psychosocial support for staff.

Professional Organizations

So too physicians and other health care professionals should be able to rely on their professional organizations to advocate for appropriate support of the health care workforce, as in fact several [organizations](#) have done over the course of the COVID-19 pandemic. In March 2020, the American Medical Association, American Hospital Association, and American Nurses Association, for example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA) to [provide PPE](#). The [American College of Physicians](#) similarly urged use of the DPA to address the shortage of PPE. [Physicians for Human Rights](#) led a coalition of organizations that called on the National Governors Association to urge governors to implement mandatory standards for protecting health workers during the pandemic.

The AMA further advocated for opening [visa processing](#) for international physicians to help address workforce issues, and secured [financial support](#) for physician practices under the Provider Relief Fund of the American Rescue Plan Act.

Public Policy

As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and society. Such obligations on the part of communities and public policymakers should be acknowledged as among the main factors that "contour the duty to treat" [1]. More specifically, it is argued,

in preparation for epidemics communities should: 1) take all reasonable precautions to prevent illness among health care workers and their families; 2) provide for the care of those who do become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and 4) provide reliable compensation for the families of those who die while fulfilling this duty [1].

In the face of the failure on the part of health care institutions and public agencies to ensure that essential resources have been in place to reduce risk and lessen the burdens for individuals of taking on the inevitable risk that remains, it is understandable that physicians and other health care professionals may resent the expectation that they will unhesitatingly put themselves at risk. At least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical heroism were overwhelmingly insensitive to the fact such heroism was the “direct, avoidable consequence” of institutional and public policy decisions that left the health care system unprepared and transferred the burden of responding to the pandemic to individual health care professionals [8].

ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

In the end, seeing the duty to treat as simply a matter of physicians’ altruistic dedication to patients forecloses considerations that can rightly condition the duty in individual circumstances. As Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians’ only obligation in a public health crisis. They equally have an obligation to be part of ensuring that care can be provided in the future. Equating duty to treat with altruism “makes invisible moral conflicts between the various parties to whom a person may owe care and interferes with the need of healthcare professionals to understand that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic” [7].

Further, such a view not only elides institutional and societal obligations but misrepresents how the duty actually plays out in contemporary health care settings. The risks posed by pandemic disease are distributed across the health care workforce, not uniquely borne by individuals, let alone by individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an obligation physicians owe to fellow health care personnel as much as to patients or to society.

AN ENDURING PROFESSIONAL RESPONSIBILITY

Taken together, the foregoing considerations argue that physicians indeed *should* recognize the duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of one’s ethical obligations

... requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Decisions to decline a duty to treat during a public health crisis carry consequences well beyond the immediate needs of individual patients. In exercising the required discernment and ethical reflection, physicians should take into account:

- the urgency of patients’ medical need and likelihood of benefit

- the nature and magnitude of risks to the physician and others to whom the physician also owes duties of care
- the resources available or reasonably attainable to mitigate risk to patients, themselves and others
- other strategies that could reasonably be implemented to reduce risk, especially for those who are most vulnerable
- the burden declining to treat will impose on fellow health care workers

Physicians who themselves have underlying medical conditions that put them at high risk for severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at high risk, have a responsibility to protect themselves as well as their patients. But protecting oneself and one's patients carries with it a responsibility to identify and act on opportunities to support colleagues who take on the risk of providing frontline care.

Physicians and other health care workers *should* be able to rely on the institutions within which they work to uphold the organization's responsibility to promote conditions that enable caregivers to meet the ethical requirements of their professions. So too, physicians and other health care workers *should* be able to trust that public policymakers will make and enforce well-considered decisions to support public health and the health care workforce. When those expectations are not met, physicians have a responsibility to advocate for change [[Principles III, IX](#)].

Yet, the failure of institutions or society does not in itself absolve physicians of their duty of fidelity to patients and the professional obligation to treat.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended by addition and deletion as follows and the remainder of this report be filed:

8.3 Physician Responsibility in Disaster Response and Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

~~However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.~~

The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.

1 Many physicians owe competing duties of care as medical professionals and as individuals
2 outside their professional roles. In a public health crisis, institutions should provide support to
3 enable physicians to meet compelling personal obligations without undermining the
4 fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to
5 allow the physician to honor both obligations are not feasible, it may be ethically acceptable for
6 a physician to limit participating in care, provided that the institution has made available
7 another mechanism for meeting patients' needs. Institutions should strive to be flexible in
8 supporting physicians in efforts to address such conflicts. The more immediately relevant a
9 physician's clinical expertise is to the urgent needs of the moment and the less that alternative
10 care mechanisms are available, the stronger the professional obligation to provide care despite
11 competing obligations.

12
13 With respect to disaster, whether natural or manmade, individual physicians should:

14
15 (a) Take appropriate advance measures, including acquiring and maintaining appropriate
16 knowledge and skills to ensure they are able to provide medical services when needed.

17
18 Collectively, physicians should:

19
20 (b) Provide medical expertise and work with others to develop public health policies that:

21
22 (i) Are designed to improve the effectiveness and availability of medical services during a
23 disaster

24 (ii) Are based on sound science

25 (iii) Are based on respect for patients

26
27 (c) Advocate for and participate in ethically sound research to inform policy decisions.
28 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

- 1 Huber SJ, Wynia MK.-When pestilence prevails ... physician responsibilities in epidemics. *Am J Bioethics* 2004;4(1):w5-w11.
- 2 Brody H, Avery EN-Medicine's duty to treat pandemic illness: solidarity and vulnerability. *Hast Center Report* 2009;1:40-48.
- 3 Arras JD.-The fragile web of responsibility: AIDS and the duty to treat. *Hast Center Report* 1988;3:10-20.
- 4 McConnell D.-Balancing the duty to treat with the duty to family in the context of the COVID-19 pandemic. *J Med Ethics* 2020;46:360-363.
- 5 Bakewell F, Pauls MA, Migneault D.-Ethical considerations of the duty to care and physician safety in the COVID-19 pandemic. *CJEM* 2020;22(4):407-410.
- 6 Orentlicher D.-The physician's duty to treat during pandemics. *Am J Public Health* 2018;108(11):1459-1461.
- 7 Reid L.-Diminishing returns? risk and the duty to care in the SARS epidemic. *Bioethics* 2005;19(4):348-361.
- 8 Shuklenk U.-What health care professionals owe us: why their duty to treat during a pandemic is contingent on personal protective equipment (PPE). *J Med Ethics* 2020;46:432-435.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-22)

Introduced by: Resident and Fellow Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,
3 organizations, and entire countries, based on US foreign policy and national security goals¹; and
4

5 Whereas, Primary sanctions prohibit U.S.-based individuals and entities from economic
6 transactions with the target nation, while secondary sanctions prohibit non-U.S. entities from
7 conducting any financial transaction that requires routing through U.S.-based institutions, such
8 as currency exchange²; and
9

10 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against
11 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and
12 against individuals in nineteen other nations and territories (Bangladesh, Belarus, Central
13 African Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon,
14 Liberia, Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and
15 Zimbabwe)³; and
16

17 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,
18 economic sanctions fail to do so, and instead contribute to military escalation and increased
19 violence^{4,5}; and
20

21 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two
22 most notable successes being the fall of the apartheid regime in South Africa (after three
23 decades of economic sanctions and arms embargoes), and the fall of the government of
24 Rhodesia after over ten years of sanctions and civil war⁶; and
25

26 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,
27 imposing suffering on innocent civilians within the targeted nations in order to force a surrender
28 by the ruling class⁷; and
29

30 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed
31 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on
32 women, caused by an increase in child mortality and in deaths due to cholera⁸; and
33

34 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%
35 compared to non-sanctioned nations, with the impact lasting for 21 years⁹; and
36

37 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by
38 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating
39 the disproportionate impact of sanctions on marginalized populations¹⁰; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in
4 target nations^{11,12}; and

5
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic
7 growth in target nations and decrease their GDP per capita by 13.4%¹³; and

8
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among
11 children aged 1-4 years old¹⁴; and

12
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to
14 basic medical supplies including syringes and masks, medicines, vaccines, and food¹⁵; and

15
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, "Iranians'
18 access to essential medicine and their right to health is being negatively impacted, threatening
19 the health of millions of Iranians"^{12,16}; and

20
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions
23 led the editors of several other journals to reject them, with one stating that "US owned journals
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed
25 by the Government of Iran"¹⁷; and

26
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran
28 led to an increase in inflation and unemployment, a devaluation of the nation's currency, scarcity
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,
30 women, and children and found no positive effect from existing "humanitarian exemptions"¹⁸;
31 and

32
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened
34 in the past decade, have contributed to a breakdown in its healthcare system, including
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare
36 parts to maintain these machines or license software to run them¹⁹; and

37
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-
39 national legal teams to navigate EU and US sanctions exemption applications¹⁹; and

40
41 Whereas, US and EU-led economic sanctions on Syria have contributed to devaluation of the
42 Syrian currency, shortages of fuel, electricity, medicines, and water, a drop in agricultural and
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against
44 COVID-19²⁰; and

45
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US
47 sanctions imposed after the fall of the Afghan government in 2021²¹; and

48
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer
51 aid money into the country for fear of triggering secondary sanctions²²; and

1 Whereas, In February 2022, the Biden administration announced it would relax some sanctions
2 on Afghanistan, including allowing half of the Afghan Central Bank's assets in the US to be used
3 to pay for humanitarian purchases such as food and medicine, while continuing to freeze the
4 other half, in a move that was described as "aiming to make it harder to blame the US
5 government's sanctions for the unfolding economic disaster in Afghanistan"²³; and
6

7 Whereas, Freezing the Afghan Central Bank's reserves has contributed to a crash in the Afghan
8 currency's value, leading to a rise in food prices over 40% since the previous year²⁴; and
9

10 Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study
11 on the humanitarian impact of economic sanctions¹²; and
12

13 Whereas, The United Nation's (UN) Committee on Economic, Social, and Cultural Rights states
14 that nations that impose economic sanctions must take steps to respond to any disproportionate
15 suffering experienced by vulnerable groups within the targeted country²⁵; and
16

17 Whereas, The UN's Office of the High Commissioner for Human Rights has found that unilateral
18 economic sanctions disproportionately harm women, children, and marginalized groups, and
19 that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or
20 minimizing these sanctions^{26,27}; and
21

22 Whereas, The World Medical Association "urges national medical associations to ensure that
23 Governments employing economic sanctions against other States respect the agreed
24 exemptions for medicines, medical supplies, and basic food items"²⁸; and
25

26 Whereas, Lawmakers in the US have called for a report on the humanitarian impact of
27 sanctions, most recently through a February 2022 letter signed by over twenty members of
28 Congress^{29,30}; and
29

30 Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly
31 urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does
32 not have policy discussing the harmful health costs of economic sanctions; therefore be it
33

34 RESOLVED, That our American Medical Association recognize that economic sanctions can
35 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it
36 further
37

38 RESOLVED, That our AMA support efforts to study the humanitarian impact of economic
39 sanctions imposed by the United States. (New HOD Policy)

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

Received: 09/14/22

REFERENCES:

1. Office of Foreign Assets Control - sanctions programs and information. U.S. Department of the Treasury. <https://home.treasury.gov/policy-issues/office-of-foreign-assets-control-sanctions-programs-and-information>. Published April 13, 2022. Accessed April 15, 2022.
2. Bartlett J, Ophel M. Sanctions by the numbers: U.S. Secondary Sanctions. Center for a New American Security. <https://www.cnas.org/publications/reports/sanctions-by-the-numbers-u-s-secondary-sanctions>. Published August 26, 2021. Accessed April 13, 2022.
3. Sanctions programs and country information. U.S. Department of the Treasury. <https://home.treasury.gov/policy-issues/financial-sanctions/sanctions-programs-and-country-information>. Published April 12, 2022. Accessed April 13, 2022.
4. Hultman L, Peksen D. Successful or counterproductive coercion? The effect of international sanctions on conflict intensity. 2017. *Journal of Conflict Resolution*, 61(6), 1315–1339.
5. Lektzian DJ, Sprecher CM. Sanctions, signals, and militarized conflict. 2007. *Am J Pol Sci*. 2007. 51(2). 415-431
6. Pape RA. Why economic sanctions still do not work. *International Security*. 1998. 23(1)66-77.
7. Karuka M. Chapter 3: Hunger Politics: Sanctions as Siege Warfare. Davis S, Ness I eds. *Sanctions as War*. 2022;51-62.
8. Gutmann J, Neuenkirch M, Neumeier F. Sanctioned to death? The impact of economic sanctions on life expectancy and its gender gap. *J Dev Stud* 2021;57:139–62.doi:10.1080/00220388.2020.1746277
9. Neuenkirch M, Neumeier F. The impact of US sanctions on poverty. *J Dev Econ* 2016;121:110–9.doi:10.1016/j.jdeveco.2016.03.005
10. Kim Y. Economic sanctions and child HIV. *Int J Health Plann Manage* 2019;34:693–700.doi:10.1002/hpm.2727
11. Afesorgbor S. Sanctioned to starve? the impact of economic sanctions on food security in targeted states. SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3660536. Published September 3, 2020. Accessed April 13, 2022.
12. Sepheri Far T. "Maximum pressure". Human Rights Watch. <https://www.hrw.org/report/2019/10/29/maximum-pressure/us-economic-sanctions-harm-iranians-right-health>. Published May 26, 2020. Accessed April 13, 2022.
13. Kim Y. Economic sanctions and child HIV. *The International Journal of Health Planning and Management*. 2019;34(2):693-700. doi:10.1002/hpm.2727
14. Gibbons E, Garfield R. The impact of economic sanctions on health and human rights in Haiti, 1991-1994. *American Journal of Public Health*. 1999;89(10):1499-1504. doi:10.2105/ajph.89.10.1499
15. Oxfam. Right to live without a blockade. <https://www.oxfamamerica.org/explore/research-publications/right-to-live-without-a-blockade/>. Published May 25, 2021. Accessed April 14 2022.
16. Asadi-Pooya AA, Azizimalamiri R, Badv RS, et al. Impacts of the International economic sanctions on Iranian patients with epilepsy. *Epilepsy Behav* 2019;95:166–8.
17. Arie S. Unintended consequences of sanctions against Iran. *BMJ* 2013;347:f4650. doi:10.1136/bmj.f4650
18. Kokabisaghi F. Assessment of the effects of economic sanctions on Iranians' right to health by using human rights impact assessment tool: a systematic review. *Int J Health Policy Manag* 2018;7:374–93.
19. Bulos N. For many Syrians, 'smart' sanctions are anything but. *Los Angeles Times*. <https://www.latimes.com/world/la-fg-syria-sanctions-20181212-story.html>. Published December 24, 2018. Accessed April 13, 2022.
20. Aita S. The Unintended Consequences of the US and European Unilateral Measures on Syria's Economy. The Carter Center. https://www.cartercenter.org/resources/pdfs/peace/conflict_resolution/syria-conflict/syria-unintended-consequences-aita-12-20.pdf. Published Dec 2020. Accessed April 14, 2022.
21. Constable P. As Afghanistan's harsh winter sets in, many are forced to choose between food and warmth. *The Washington Post*. <https://www.washingtonpost.com/world/2022/01/08/afghanistan-winter-crisis/>. Published January 8, 2022. Accessed April 13, 2022.
22. Abbasi F. Time running out to address Afghanistan's hunger crisis. Human Rights Watch. <https://www.hrw.org/news/2022/03/17/time-running-out-address-afghanistans-hunger-crisis>. Published March 24, 2022. Accessed April 13, 2022.
23. Savage C. U.S. eases sanctions to allow routine transactions with Afghan government. *The New York Times*. <https://www.nytimes.com/2022/02/25/us/politics/us-sanctions-afghanistan.html>. Published February 26, 2022. Accessed April 13, 2022.
24. Afghanistan Economic Monitor. World Bank. <https://thedocs.worldbank.org/en/doc/0fa267944e2b004e4dba35e9b014bd89-0310062021/related/Afghanistan-Economic-Monitor-15-February-2022.pdf>. Published February 15, 2022. Accessed April 14, 2022.
25. Committee on Economic, Social and Cultural Rights. General Comment 8, The relationship between economic sanctions and respect for economic, social and cultural rights (Seventeenth session, 1997), U.N. Doc. E/C.12/1997/8 (1997), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 50 (2003). <http://hrlibrary.umn.edu/gencomm/escgencom8.htm>. Accessed April 15, 2022.
26. OHCHR. Unilateral sanctions hurt all, especially women, children, and other vulnerable groups - UN human rights expert. United Nations. <https://www.ohchr.org/en/press-releases/2021/12/unilateral-sanctions-hurt-all-especially-women-children-and-other-vulnerable>. Published Dec 08, 2021. Accessed April 14, 2022.
27. OHCHR. US must remove sanctions and allow Syria to rebuild - UN expert. United Nations. <https://www.ohchr.org/en/press-releases/2020/12/us-must-remove-sanctions-and-allow-syria-rebuild-un-expert?LangID=E&NewsID=26630>. Published Dec 29, 2020. Accessed April 14, 2022.
28. World Medical Association. WMA resolution on economic embargoes and health. <https://www.wma.net/policies-post/wma-resolution-on-economic-embargoes-and-health/>. Published April 12, 2022. Accessed April 15, 2022.
29. Jayapal P. H.Amdt. 165 to H.R.4521. Congress.gov. <https://www.congress.gov/amendment/117th-congress/house-amendment/165/text?r=6&am=s=a>. Published February 3, 2022. Accessed April 14, 2022.
30. Omar I, Garcia JG, Warren E, et al. Letter to President Biden. House.gov. <https://omar.house.gov/sites/omar.house.gov/files/sanctions%20letter%20final%20text%5B1%5D.pdf>. Published February 11, 2021. Accessed April 14, 2022.

RELEVANT AMA POLICY

Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Citation: Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

Citation: BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Citation: Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-22)

Introduced by: Medical Student Section

Subject: Indigenous Data Sovereignty

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, There is a history of research misconduct against American Indian and Alaska Native
2 (AI/AN) Tribes and Villages¹; and
3

4 Whereas, One notable example of this misconduct was a psychiatric biomarkers study on
5 members of the Havasupai Indian Tribe conducted by researchers at Arizona State University
6 without prior, informed and free consent^{2,3}; and
7

8 Whereas, Havasupai Indian Tribe v. Arizona State University resulted in a punitive settlement
9 against Arizona State University and indirectly led to moratorium on all genetic research on
10 members of the neighboring Navajo Nation⁴; and
11

12 Whereas, The Indian Health Service and Tribal leaders developed frameworks and guidelines
13 for Tribal Institutional Review Boards (IRB)⁵; and
14

15 Whereas, All research conducted on an American Indian and Alaska Native reservation requires
16 the approval of the Indian Health Service Area IRB or respective Tribal IRB⁵; and
17

18 Whereas, A Tribal IRB assumes responsibility for the ethical review and oversight of all
19 research occurring on Tribal land, including the protection of human subjects, the Tribe, Tribal
20 communities, and Tribal resources (including environmental, animal, plant and cultural
21 resources)⁶; and
22

23 Whereas, A Tribal IRB differs from an Academic IRB by allowing for community members and
24 Tribal leadership to provide input into research design and conduct and the prioritization of
25 research linked to community priorities^{5, 7}; and
26

27 Whereas, A Tribal IRB ensures that the principles of Indigenous Data Sovereignty, defined as
28 the right of each American Indian and Alaska Native Tribe and Villages to control the collection,
29 ownership, and application of their own data are upheld^{8,9}; and
30

31 Whereas, While federal research protections for American Indian and Alaska Native Tribes and
32 Villages are enforceable on Tribal lands and properties, there are complex jurisdictional issues
33 preventing their timely enforcement off of Tribal lands and properties¹⁰; and
34

35 Whereas, Federal programs such as the NIH All of Us Research Program have sought to
36 address these challenges by incorporating best practices and maximizing American Indian and
37 Alaska Native participation in policy and program design¹¹; and

Whereas, An example of a best practice used by All of Us includes ensuring “that research using the program’s biospecimens and data from [T]ribal members is done in a way that is respectful of applicable [T]ribal customs, culture, and laws”¹²; and

Whereas, Existing best practices for working with American Indian and Alaska Native Tribes and Villages include the the use of data-sharing agreements, which also specify rules for data sharing and ownership¹³; and

Whereas, Tribal government officials, liaisons, and elected leaders are recommended to have shared decision-making and oversight over research affairs specific to their members⁵; and therefore be it

RESOLVED, That our American Medical Association recognize that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties (New HOD Policy); and be it further

RESOLVED, That our AMA support that AI/AN Tribes and Villages’ Institutional Review Boards (IRBs) and research departments retain the right to oversee and regulate the collection, ownership, and management of research data generated by their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46 (New HOD Policy); and it be further

RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 09/20/22

References:

1. Pacheco, C. et al. Moving Forward: Breaking the Cycle of Mistrust Between American Indians and Researchers. *Am J Public Health*. 2015 Dec; 103(12):2152-2159.
2. Pacheco, C. M., Daley, S. M., Brown, T., Filippi, M., Greiner, K. A., & Daley, C. M. (2013). Moving forward: breaking the cycle of mistrust between American Indians and researchers. *American journal of public health*, 103(12), 2152–2159. <https://doi.org/10.2105/AJPH.2013.301480>
3. Mello, M.M. and Wolf, L.E. The Havasupai Indian Tribe Case - Lessons for Research Involving Stored Biologic Samples. *New England Journal of Medicine*. 2010, July; 363:204-207.
4. Sterling, R.L. Genetic Research among the Havasupai: A Cautionary Tale. *AMA Journal of Ethics*. 2011;13(2):113-117.
5. Around Him, D. et al., Tribal IRBs: A Framework for Understanding Research Oversight in American Indian and Alaska Native Communities. *Am Indian Alsk Native Ment Health Red*. 2019;26(2):71-95.
6. Collaborative Research Center for American Indian Health. (2015). CRCAIH Tribal IRB Toolkit. Angal, J and Andalcio, T. Authors.
7. Morton, D.J., Proudfit, J., Calac, D., Portillo, M., Lofton-Fitzsimmons, G., Molina, T., Majel-McCauley, R. (2013). Creating research capacity through a Tribally based institutional review board. *Am J Public Health*, 103 (12), 2160-2164. doi: 10.2015/ajph.2013.301473
8. Rainie, Stephanie Carroll, Desi Rodriguez-Lonebear, and Andrew Martinez. 2017. *Policy Brief (Version 2): Data Governance for Native Nation Rebuilding*. Tucson: Native Nations Institute.
9. Carroll SR, Rodriguez-Lonebear D, Martinez A. Indigenous Data Governance: Strategies from United States Native Nations. *Data Sci J*. 2019;18:31. doi:10.5334/dsj-2019-031
10. Bledsoe, M.J. and Grizzle, W.E. Use of human specimens in research: the evolving United States regulatory, policy, and scientific landscape. *Diagn Histopathol (Oxf)*. 2014 Sep; 19(9):322-330.

11. The Tribal Collaboration Working Group Report to the *All of Us* Research Program Advisory Panel. "Considerations for Meaningful Collaboration with Tribal Populations". *National Institutes of Health*, U.S. Department of Health and Human Services, 2018, National Institutes of Health, All of Us Research Program. "All of Us Tribal Engagement." *National Institutes of Health*, U.S. Department of Health and Human Services, <https://allofus.nih.gov/about/diversity-and-inclusion/Tribal-engagement>.
12. National Institutes of Health, All of Us Research Program. "All of Us Tribal Engagement." *National Institutes of Health*, U.S. Department of Health and Human Services, <https://allofus.nih.gov/about/diversity-and-inclusion/Tribal-engagement>.
13. Warren-Mears, V. Principles and models for data sharing agreements with American Indian/Alaska Native communities. *Northwest Portland Area Indian Health Board Tribal Epidemiology Center*. 2015. Accessed April 15, 2022. <https://static1.squarespace.com/static/58e9b10f9de4bb8d1fb5ebbc/t/592a6d81bebafb216b51a61b/1495952772545/Principles+and+Models+for+Data+Sharing+Agreements.pdf>

RELEVANT AMA POLICY

E-7.3.7 Safeguards in the Use of DNA Databanks

DNA databanks facilitate population-based research into the genetic components of complex diseases. These databanks derive their power from integrating genetic and clinical data, as well as data on health, lifestyle, and environment about large samples of individuals. However, the use of DNA databanks in genomic research also raises the possibility of harm to individual participants, their families, and even populations.

Breach of confidentiality of information contained in DNA databanks may result in discrimination or stigmatization and may carry implications for important personal choices, such as reproductive choices. Human participants who contribute to research involving DNA databanks have a right to be informed about the nature and scope of the research and to make decisions about how their information may be used.

In addition to having adequate training to be able to discuss genomic research and related ethical issues with patients or prospective research participants, physician-researchers who are involved in genomic research using DNA databanks should:

Research involving individuals

- (a) Obtain informed consent from participants in genomic research, in keeping with ethics guidance. In addition, physicians should put special emphasis in the consent process on disclosing:
 - (i) the specific privacy standards to which the study will adhere, including whether the information or biological sample will be encrypted and remain identifiable to the researcher or will be completely de-identified;
 - (ii) whether participants whose data will be encrypted rather than de-identified can expect to be contacted in the future about findings or be invited to participate in additional research, either related to the current protocol or for other research purposes;
 - (iii) whether researchers or participants stand to gain financially from research findings, and any conflicts of interest researchers may have in regard to the research, in keeping with ethics guidance;
 - (iv) when, if ever, archived information or samples will be discarded;
 - (v) participants' freedom to refuse use of their biological materials without penalty.

Research involving identifiable communities

- (b) When research is to be conducted within a defined subset of the general population, physicians should:
 - (i) consult with the community in advance to design a study that is sensitive to community concerns and that will minimize harm for the community, as well as for individual participants. Physicians should not carry out a study when there is substantial opposition to the research within the community of interest;
 - (ii) protect confidentiality by encrypting any demographic or identifying information that is not required for the study's purpose.

[AMA Principles of Medical Ethics: I,IV,V,VII](#)

Issued: 2016

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a

position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19, Reaffirmed: CMS Rep. 3, A-21, Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Support for Institutional Review Boards H-460.921

Our AMA: (1) commends the thousands of Institutional Review Board (IRB) members who each have volunteered hundreds of hours annually; (2) urges medical schools and teaching hospitals to provide IRBs with adequate personnel and other resources to accomplish their mission to safeguard the rights

and welfare of human research subjects; and (3) encourages the National Institutes of Health to develop a program that provides flexible funding to institutions, including support directed at IRBs. Res. 317, I-98, Reaffirmed: Res. 528, A-00, Modified: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18, Reaffirmation: A-19

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.

Res. 233, A-13, Appended: Res. 229, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-22)

Introduced by: Medical Student Section

Subject: Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Association of Native American Medical Students has communicated to the
2 AMA-MSS Committee on American Indian Affairs, Association of American Medical Colleges,
3 National Residency Matching Program, and Accreditation Council for Graduate Medical
4 Education that they have received reports of residency interviewers asking American Indian and
5 Alaska Native applicants inappropriate interview questions about blood quantum¹; and
6

7 Whereas, Mathematical blood quantum was implemented by the federal government, requiring
8 the Bureau of Indian Affairs (BIA) to issue a Certificate Degree of Indian Blood (CDIB) that
9 provided evidence of descent from pureblood (full-fraction) Tribal members^{2,3}; and
10

11 Whereas, The role of blood quantum in the identity of Indigenous Peoples is a topic of
12 controversy, with foundations in colonization and disenfranchisement^{2,4}; and
13

14 Whereas, There is no practical or biological basis for blood quantum and its persistence in these
15 communities is a relic of external governmental influences⁴; and
16

17 Whereas, Many Tribes have foregone blood quantum as a determinant in favor of direct lineage,
18 while the Tribes that continue to evaluate lineage by blood quantum have no absolute
19 minimum⁴; and
20

21 Whereas, Of the racial groups defined in the United States Census, American Indians and
22 Alaskan Natives are the only group that have identity associated with fractions of blood (blood
23 quantum), which may introduce significant potential for discrimination⁴; and
24

25 Whereas, Multiple evidence-based studies detailed the complexities of Indigenous identity
26 formation and the specific barriers that cause exclusion of Indigenous learners that lead to
27 continued underrepresentation of Indigenous students in all stages of medical training^{5,6}; and
28

29 Whereas, It is recognized that current admissions and interview practices, whether intentionally
30 or unintentionally, may be racially biased; studies suggest that creating a culturally safe
31 environment in interviews can successfully reduce racial biases⁵; and
32

33 Whereas, Compared to other residency interview methods, 64% of unstructured interviews were
34 found to include inappropriate questions about applicant marital status, family planning,
35 ethnicity, and religion, despite the presence of anti-discrimination laws, which greatly increases
36 bias and applicant stereotyping⁷; and

Whereas, The AAMC's Best Practice Guidelines for Residency Program Interviews encourage the use of standardized interview content, clearly defined criteria, scoring guidelines, and interview training to decrease bias and applicant stereotyping⁸; and

Whereas, Addressing structural, interpersonal, and individual bias in residency selection has been shown to increase the percentage of entering underrepresented minority interns⁹;

Whereas, American Indian and Alaskan Native applicants subjected to questioning about their blood quantum may discourage applicants from advancing their education, further exacerbating the shortage of American Indian medical trainees¹⁰; and

Whereas, Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs (H-350.981); and

Whereas, Our AMA opposes questions regarding applicant race during the medical school, residency, and fellowship application process (H-310.919), but questioning based on American Indian and Alaska Native "blood quantum" is not based on race¹¹; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process. (Directive to Take Action)

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

Received: 09/20/22

References:

1. Association of Native American Medical Students. Private email communication to AMA Medical Student Section Committee on American Indian Affairs. November 2021.
2. Indian Reorganization Act, 25 U.S.C. ch. 14, subch. V § 461 et seq. (1934)
3. Genealogy. US Department of the Interior Indian Affairs. <https://www.bia.gov/bia/ois/tgs/genealogy>
4. Harmon M. Blood Quantum and the White Gatekeeping of Native American Identity. California Law Review. 2021;109. Accessed March 4, 2022. <https://www.californialawreview.org/blood-quantum-and-the-white-gatekeeping-of-native-american-identity/>
5. Soucy, D. N., & Wieman, C. (2020). Where are you From? Reframing Facilitated Admissions Policies in the Faculty of Health Sciences. *aboriginal policy studies*, 9(1).
6. Brodt E, Valenzuela S, Empey A, et al. Measurement of American Indian and Alaska Native Racial Identity Among Medical School Applicants, Matriculants, and Graduates, 1996-2017. *JAMA Netw Open*. 2021;4(1):e2032550. doi:10.1001/jamanetworkopen.2020.32550
7. Marbin, J., Rosenbluth, G., Brim, R., Cruz, E., Martinez, A., & McNamara, M. (2021). Improving diversity in pediatric residency selection: using an equity framework to implement holistic review. *Journal of Graduate Medical Education*, 13(2), 195-200.
8. Gardner, A. K. (2018). How can best practices in recruitment and selection improve diversity in surgery?. *Annals of surgery*, 267(1), e1-e2.
9. Association of American Medical Colleges. Best Practices for Conducting Residency Program Interviews. <https://www.aamc.org/system/files/2020-05/best%20practices%20for%20conducting%20residency%20program%20interviews.pdf>. Accessed March 19, 2022.
10. Masta, S. (2018). 'I am exhausted': everyday occurrences of being Native American. *International Journal of Qualitative Studies in Education*, 31(9), 821-835.
11. Rodriguez-Lonebear D. The Blood Line: Racialized Boundary Making and Citizenship among Native Nations. *Sociology of Race and Ethnicity*. 2021;7(4):527-542. doi:10.1177/2332649220981589

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of

training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any

organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. 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; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. 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; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

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

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Residency Interview Costs H-310.966

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.

Res. 265, A-90, Reaffirmed: Sunset Report, I-00, Modified: CME Rep. 2, A-10, Appended: Res. 308, A-15

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations

regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.

Res. 960, I-17

Educating Competent and Caring Health Professionals H-295.975

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize that they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.

BOT Rep. NN, A-87, Modified: Sunset Report, I-97, Reaffirmed: CME Rep. 2, A-07, Reaffirmed: CME Rep. 01, A-17

Residency Interview Schedules H-310.998

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Res. 93, I-79, Reaffirmed: CLRPD Rep. B, I-89, Appended: Res. 302 and Res. 313, I-97, Reaffirmed: CME Rep. 2, A-07, Modified: Res. 302, A-14, Appended: Res. 314, A-19

Gender-Based Questioning in Residency Interviews H-310.976

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes

changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Res. 125, I-88, Reaffirmed: Sunset Report, I-98, Modified and Reaffirmed: CME Rep. 2, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13

Housestaff Input During the ACGME Review Process H-310.952

The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty.

Res. 314, I-92, Reaffirmed: CME Rep. 2, A-03, Reaffirmed: CME Rep. 2, A-13

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

Res. 325, A-03, Appended: CME Rep. 6, A-11, [Modified: CME Rep. 3, A-13](#), [Appended: CME Rep. 5, A-21](#)

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: CME Rep. 1, A-22

Competency-Based Portfolio Assessment of Medical Students D-295.318

1. Our AMA will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.

2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Res. 314, A-10, Appended: Res. 311, A-14

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants; 4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and 5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Res. 307, A-09 Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-22)

Introduced by: Medical Student Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,
3 organizations, and entire countries, based on US foreign policy and national security goals¹;
4 and

5
6 Whereas, Primary sanctions prohibit US-based individuals and entities from economic
7 transactions with the target nation, while secondary sanctions prohibit non-US entities from
8 conducting any financial transaction that requires routing through US-based institutions, such as
9 currency exchange²; and

10
11 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against
12 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and
13 against individuals in 19 other nations and territories (Bangladesh, Belarus, Central African
14 Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon, Liberia,
15 Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and Zimbabwe)³;
16 and

17
18 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,
19 economic sanctions fail to do so, and instead contribute to military escalation and increased
20 violence^{4,5}; and

21
22 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two
23 most notable successes being the fall of the apartheid regime in South Africa (after three
24 decades of economic sanctions and arms embargoes), and the fall of the government of
25 Rhodesia after over ten years of sanctions and civil war⁶; and

26
27 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,
28 imposing suffering on innocent civilians within the targeted nations in order to force a surrender
29 by the ruling class⁷; and

30
31 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed
32 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on
33 women, caused by an increase in child mortality and in deaths due to cholera⁸; and

34
35 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%
36 compared to non-sanctioned nations, with the impact lasting for 21 years⁹; and

37
38 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by
39 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating
40 the disproportionate impact of sanctions on marginalized populations¹⁰; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in
4 target nations^{11,12}; and

5
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic
7 growth in target nations and decrease their GDP per capita by 13.4%¹³; and

8
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among
11 children aged 1-4 years old¹⁴; and

12
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to
14 basic medical supplies including syringes and masks, medicines, vaccines, and food¹⁵; and

15
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, "Iranians'
18 access to essential medicine and their right to health is being negatively impacted, threatening
19 the health of millions of Iranians"^{12,16}; and

20
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions
23 led the editors of several other journals to reject them, with one stating that "US owned journals
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed
25 by the Government of Iran"¹⁷; and

26
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran
28 led to an increase in inflation and unemployment, a devaluation of the nation's currency, scarcity
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,
30 women, and children and found no positive effect from existing "humanitarian exemptions"¹⁸;
31 and

32
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened
34 in the past decade, have contributed to a breakdown in its healthcare system, including
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare
36 parts to maintain these machines or license software to run them¹⁹; and

37
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-
39 national legal teams to navigate EU and US sanctions exemption applications¹⁹; and

40
41 Whereas, US- and EU-led economic sanctions on Syria have contributed to devaluation of the
42 Syrian currency, shortages of fuel, electricity, and medicines, water, a drop in agricultural and
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against COVID-
44 19²⁰; and

45
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US
47 sanctions imposed after the fall of the Afghan government in 2021²¹; and

48
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer
51 aid money into the country for fear of triggering secondary sanctions²²; and

Whereas, In February 2022, the Biden administration announced it would relax some sanctions on Afghanistan, including allowing half of the Afghan Central Bank's assets in the US to be used to pay for humanitarian purchases such as food and medicine, while continuing to freeze the other half, in a move that was described as "aiming to make it harder to blame the US government's sanctions for the unfolding economic disaster in Afghanistan"²³; and

Whereas, Freezing the Afghan Central Bank's reserves has contributed to a crash in the Afghan currency's value, leading to a rise in food prices over 40% since the previous year²⁴; and

Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study on the humanitarian impact of economic sanctions¹²; and

Whereas, The United Nation's (UN) Committee on Economic, Social, and Cultural Rights states that nations that impose economic sanctions must take steps to respond to any disproportionate suffering experienced by vulnerable groups within the targeted country²⁵; and

Whereas, The UN's Office of the High Commissioner for Human Rights has found that unilateral economic sanctions disproportionately harm women, children, and marginalized groups, and that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or minimizing these sanctions^{26,27}; and

Whereas, The World Medical Association "urges national medical associations to ensure that Governments employing economic sanctions against other States respect the agreed exemptions for medicines, medical supplies, and basic food items"²⁸; and

Whereas, Lawmakers in the US have called for a report on the humanitarian impact of sanctions, most recently through a February 2022 letter signed by over twenty members of Congress^{29,30}; and

Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does not have policy discussing the harmful health costs of economic sanctions; therefore be it

RESOLVED, That our American Medical Association recognize that economic sanctions can negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it further

RESOLVED, That our AMA support legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States. (New HOD Policy)

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

Received: 09/20/22

REFERENCES:

1. Office of Foreign Assets Control - sanctions programs and information. US Department of the Treasury. <https://home.treasury.gov/policy-issues/office-of-foreign-assets-control-sanctions-programs-and-information>. Published April 13, 2022. Accessed April 15, 2022.
2. Bartlett J, Ophel M. Sanctions by the numbers: US Secondary Sanctions. Center for a New American Security. <https://www.cnas.org/publications/reports/sanctions-by-the-numbers-u-s-secondary-sanctions>. Published August 26, 2021. Accessed April 13, 2022.
3. Sanctions programs and country information. US Department of the Treasury. <https://home.treasury.gov/policy-issues/financial-sanctions/sanctions-programs-and-country-information>. Published April 12, 2022. Accessed April 13, 2022.
4. Hultman L, Peksen D. Successful or counterproductive coercion? The effect of international sanctions on conflict intensity. 2017. Journal of Conflict Resolution, 61(6), 1315–1339.

5. Lektzian DJ, Sprecher CM. Sanctions, signals, and militarized conflict. 2007. *Am J Pol Sci*. 2007. 51(2). 415-431
6. Pape RA. Why economic sanctions still do not work. *International Security*. 1998. 23(1)66-77.
7. Karuka M. Chapter 3: Hunger Politics: Sanctions as Siege Warfare. Davis S, Ness I eds. *Sanctions as War*. 2022;51-62.
8. Gutmann J, Neuenkirch M, Neumeier F. Sanctioned to death? The impact of economic sanctions on life expectancy and its gender gap. *J Dev Stud* 2021;57:139–62.doi:10.1080/00220388.2020.1746277
9. Neuenkirch M, Neumeier F. The impact of US sanctions on poverty. *J Dev Econ* 2016;121:110–9.doi:10.1016/j.jdeveco.2016.03.005
10. Kim Y. Economic sanctions and child HIV. *Int J Health Plann Manage* 2019;34:693–700.doi:10.1002/hpm.2727
11. Afesorgbor S. Sanctioned to starve? the impact of economic sanctions on food security in targeted states. SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3660536. Published September 3, 2020. Accessed April 13, 2022.
12. Sepheri Far T. "Maximum pressure". Human Rights Watch. <https://www.hrw.org/report/2019/10/29/maximum-pressure/us-economic-sanctions-harm-iranians-right-health>. Published May 26, 2020. Accessed April 13, 2022.
13. Kim Y. Economic sanctions and child HIV. *The International Journal of Health Planning and Management*. 2019;34(2):693-700. doi:10.1002/hpm.2727
14. Gibbons E, Garfield R. The impact of economic sanctions on health and human rights in Haiti, 1991-1994. *American Journal of Public Health*. 1999;89(10):1499-1504. doi:10.2105/ajph.89.10.1499
15. Oxfam. Right to live without a blockade. <https://www.oxfamamerica.org/explore/research-publications/right-to-live-without-a-blockade/>. Published May 25, 2021. Accessed April 14 2022.
16. Asadi-Pooya AA, Azizimalamiri R, Badv RS, et al. Impacts of the International economic sanctions on Iranian patients with epilepsy. *Epilepsy Behav* 2019;95:166–8.
17. Arie S. Unintended consequences of sanctions against Iran. *BMJ* 2013;347:f4650. doi:10.1136/bmj.f4650
18. Kokabisaghi F. Assessment of the effects of economic sanctions on Iranians' right to health by using human rights impact assessment tool: a systematic review. *Int J Health Policy Manag* 2018;7:374–93.
19. Bulos N. For many Syrians, 'smart' sanctions are anything but. *Los Angeles Times*. <https://www.latimes.com/world/la-fg-syria-sanctions-20181212-story.html>. Published December 24, 2018. Accessed April 13, 2022.
20. Aita S. The Unintended Consequences of the US and European Unilateral Measures on Syria's Economy. The Carter Center. https://www.cartercenter.org/resources/pdfs/peace/conflict_resolution/syria-conflict/syria-unintended-consequences-aita-12-20.pdf. Published Dec 2020. Accessed April 14, 2022.
21. Constable P. As Afghanistan's harsh winter sets in, many are forced to choose between food and warmth. *The Washington Post*. <https://www.washingtonpost.com/world/2022/01/08/afghanistan-winter-crisis/>. Published January 8, 2022. Accessed April 13, 2022.
22. Abbasi F. Time running out to address Afghanistan's hunger crisis. Human Rights Watch. <https://www.hrw.org/news/2022/03/17/time-running-out-address-afghanistans-hunger-crisis>. Published March 24, 2022. Accessed April 13, 2022.
23. Savage C. US eases sanctions to allow routine transactions with Afghan government. *The New York Times*. <https://www.nytimes.com/2022/02/25/us/politics/us-sanctions-afghanistan.html>. Published February 26, 2022. Accessed April 13, 2022.
24. Afghanistan Economic Monitor. World Bank. <https://thedocs.worldbank.org/en/doc/0fa267944e2b004e4dba35e9b014bd89-0310062021/related/Afghanistan-Economic-Monitor-15-February-2022.pdf>. Published February 15, 2022. Accessed April 14, 2022.
25. Committee on Economic, Social and Cultural Rights. General Comment 8, The relationship between economic sanctions and respect for economic, social and cultural rights (Seventeenth session, 1997), U.N. Doc. E/C.12/1997/8 (1997), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 50 (2003). <http://hrlibrary.umn.edu/gencomm/escgencom8.htm>. Accessed April 15, 2022.
26. OHCHR. Unilateral sanctions hurt all, especially women, children, and other vulnerable groups - UN human rights expert. United Nations. <https://www.ohchr.org/en/press-releases/2021/12/unilateral-sanctions-hurt-all-especially-women-children-and-other-vulnerable>. Published Dec 08, 2021. Accessed April 14, 2022.
27. OHCHR. US must remove sanctions and allow Syria to rebuild - UN expert. United Nations. <https://www.ohchr.org/en/press-releases/2020/12/us-must-remove-sanctions-and-allow-syria-rebuild-un-expert?LangID=E&NewsID=26630>. Published Dec 29, 2020. Accessed April 14, 2022.
28. World Medical Association. WMA resolution on economic embargoes and health. <https://www.wma.net/policies-post/wma-resolution-on-economic-embargoes-and-health/>. Published April 12, 2022. Accessed April 15, 2022.
29. Jayapal P. H.Amdt.165 to H.R.4521. Congress.gov. <https://www.congress.gov/amendment/117th-congress/house-amendment/165/text?r=6&s=a>. Published February 3, 2022. Accessed April 14, 2022.
30. Omar I, Garcia JG, Warren E, et al. Letter to President Biden. House.gov. <https://omar.house.gov/sites/omar.house.gov/files/sanctions%20letter%20final%20text%5B1%5D.pdf>. Published February 11, 2021. Accessed April 14, 2022.

RELEVANT AMA POLICY

Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in

these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Sub. Res. 133, A-83, Reaffirmed: CLRPD Rep. 1, I-93, Reaffirmed: CLRPD Rep. 1, A-05, Reaffirmed: CEJA Rep. 5, A-15

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

BOT Action in response to referred for decision Res. 620, A-09, Modified: BOT Rep. 09, A-19

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-22)

Introduced by: International Medical Graduates Section

Subject: Consent for Sexual and Reproductive Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The ability of minors to provide consent for health care services including sexual and
2 reproductive health care, mental health care has expanded over the past decades; and
3

4 Whereas, Involving parents or guardians in the decision of children and adolescent health care
5 is desirable, many young people will not seek important services if they are forced to involve
6 their parents/guardian. The sexual and reproductive health care services is one of those
7 services; and
8

9 Whereas, Twenty-three states and the District of Columbia have laws that explicitly give minors
10 the authority to consent to contraceptive services. Nineteen states allow only certain categories
11 of people younger than eighteen to consent to contraceptive services; and
12

13 Whereas, Twenty-seven states and the District of Columbia specifically allow pregnant minors
14 to obtain prenatal care and delivery services without parental consent or notification; and
15

16 Whereas, There are some states which allow specific minors such as those who are married,
17 pregnant, or already parents, and high school graduates to consent for oral contraception;
18 therefore be it
19

20 RESOLVED, That our American Medical Association work with state and county medical
21 societies to advocate for legislation and legal protections: 1) allowing minors (age 12 or above)
22 to consent for sexual and reproductive health care; 2) allowing minors to consent for prenatal
23 care and delivery services; and 3) protecting physician autonomy to provide sexual and
24 reproductive health care with minor consent, without parental consent. (Directive to Take Action)

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

Received: 09/27/22

References:

1. Berlan, E. D., & Bravender, T. (2009). Confidentiality, consent, and caring for the adolescent patient. *Current opinion in pediatrics*, 21(4), 450-456.
2. Dickens, B. M., & Cook, R. J. (2005). Adolescents and consent to treatment. *International journal of gynecology & obstetrics*, 89(2), 179-184.
3. State Health Facts: Minors' Authority to Consent to Contraceptive Services, 2022, <https://www.kff.org/womens-health-policy/state-indicator/minors-authority-to-consent-to-contraceptive-services>

RELEVANT AMA POLICY

Health Care Rights of Pregnant Minors H-60.907

Our AMA will: (1) work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care; and (2) oppose any law or policy that prohibits a pregnant minor from consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures, and emergency care. (Resolution 008, A-18)

Opinion 2.2.2 Confidential Health Care for Minors

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decisionmaking authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

(i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;

(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

AMA Principles of Medical Ethics: IV

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: 008
(I-22)

Introduced by: Colorado

Subject: Support for Physicians Practicing Evidence-Based Medicine in a
Post Dobbs Era

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, In some states, physicians may face criminal penalties for providing medical
2 treatments that are the standard of care according to multiple professional organizations; and
3

4 Whereas, The failure to provide standard of care when requested by a patient and agreed to by
5 the physician violates professional legal obligations as well as primary principles of medical
6 ethics including beneficence, non-maleficence and patient autonomy; and
7

8 Whereas, Being precluded from providing quality care due to fear of legal prosecution creates
9 moral injury to the physician who would otherwise offer that care; and
10

11 Whereas, Some state laws are putting physicians in the untenable position wherein withholding
12 appropriate care that results in harm to a patient puts physicians at risk for civil liability, while
13 providing that care may expose them to state criminal sanctions; and
14

15 Whereas, The AMA Code of Ethics states that “In some cases, the law mandates conduct that
16 is ethically unacceptable. When physicians believe a law violates ethical values or is unjust,
17 they should work to change the law. In exceptional circumstances of unjust laws, ethical
18 responsibilities should supersede legal duties.”; and
19

20 Whereas, Recent commentary has encouraged professional civil disobedience reflecting “a
21 professional group’s deciding together, after frank and rational debate, to support disobedience
22 of an unjust law [which] might eventually reinforce social cohesion, elevate trust in the
23 profession, and help communities avoid tragic errors.”¹; and
24

25 Whereas, The US Supreme Court overturned Roe v Wade in June 2022, and now each state’s
26 legislature will decide if and when its citizens will have legal access to abortion care and if and
27 when its physicians will be criminalized for providing what is considered to be the standard of
28 care by multiple health-related organizations. This extraordinary change in the medico-legal
29 landscape requires reevaluation of health profession codes of ethics related to clinician
30 conscience. These codes must now be expanded to address affirmative protection for
31 “conscientious provision” in hostile environments on par with protection of conscientious
32 refusal.²; therefore be it
33

34 RESOLVED, That our American Medical Association Task Force developed under HOD Policy
35 G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When
36 Evidence-Based, Appropriate Care Is Banned or Restricted,” provide policy and strategies to
37 support physicians individually and through their medical organizations when they are required
38 by medical and ethical standards of care to act against state and federal laws (Directive to Take
39 Action); and be it further

1 RESOLVED, That our AMA work to provide support, including legal support through the AMA
2 Litigation Center, as may be appropriate, to physicians that are targeted for practicing in
3 accordance with accepted standards of medical care and medical ethics in the face of legal
4 constraint or any other disciplinary action (Directive to Take Action); and be it further
5

6 RESOLVED, That our AMA advocate for affirmative protections for “conscientious provision” of
7 care in accordance with accepted standards of medical care and medical ethics in hostile
8 environments on par with protection of “conscientious objection.” (Directive to Take Action)

Fiscal Note: Estimated cost of \$58,000 to implement this resolution.

Received: 09/30/22

1. Wynia, MK, Professional Civil Disobedience — Medical-Society Responsibilities after Dobbs, NEJM, 387;11, 9/15/2022, pp 955-961.
2. Ryan, I et al., Why the Post-Roe Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care, AMA Journal of Ethics®, September 2022, Volume 24, Number 9: E906-912

RELEVANT AMA POLICY

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine’s response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
 - a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
 - b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
 - c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
 - d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
 - e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
 - f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
 - g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Citation: Res. 621, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-22)

Introduced by: Mississippi

Subject: Medical Decision-Making Autonomy of the Attending Physician

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The majority of physicians are now employed in the United States, and many times
2 this is by hospitals; and
3

4 Whereas, Many physician employers have independently created titles for their physician
5 leaders such as Chief Executive Officer, Chief Medical Officer, Chief Medical Information
6 Officer, Chief Operating Officer, Chief Clinical Officer, Chief of Staff, etc.; and
7

8 Whereas, Many times, even though they may sometimes overlap, the stated goals of a hospital
9 administrator and an attending physician are generally not the same; and
10

11 Whereas, There can be questions of loyalties to an institution's financial bottom line or to the
12 health and wellbeing of a patient in certain situations; and
13

14 Whereas, The oath of a physician is first to do no harm; and
15

16 Whereas, Listed within the American Hospital Association's "Patient's Bill of Rights" is the
17 patient's right to be treated fairly, to know the identities of all of their healthcare providers and to
18 make decisions about their own care before and during treatment along with a long list of other
19 pertinent patient rights; and
20

21 Whereas, The autonomy of the medical decisions made about a patient rest with the attending
22 physician who is attending their care directly per our regulatory board as well as a host of other
23 governing boards and agencies; therefore be it
24

25 RESOLVED, That our American Medical Association advocate that no matter what may change
26 in regard to a physician's employment or job status, that there is a sacred relationship between
27 an attending physician and his/her patient that leads the patient's attending physician to hold the
28 ultimate authority in the medical decision-making that affects that patient (Directive to Take
29 Action); and be it further
30

31 RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts
32 the attending physician's care into question by a hospital administrator of any sort such as listed
33 above but certainly not limited to that list— physician or not- in the event of a disagreement
34 between an administrator and the attending physician regarding a decision one would call a
35 mere judgment call, the onus would be on the administrator to prove to an ethics committee
36 why the attending physician is wrong prior to anyone having the authority to overturn or overrule
37 the order of the physician attending the patient directly (Directive to Take Action); and be it
38 further

1 RESOLVED, That our AMA reaffirm that the responsibility for the care of the individual patient
2 lies with a prudent and responsible attending physician, and that his/her decisions should not
3 easily be overturned unless there has been an egregious and dangerous judgment error made,
4 and this would still call for an ethics committee consult in that instance (Reaffirm HOD Policy);
5 and be it further

6
7 RESOLVED, That our AMA aggressively pursue any encroachment of administrators upon the
8 medical decision making of attending physicians that is not in the best interest of patients as
9 strongly as possible, for there is no more sacred relationship than that of a doctor and his/her
10 patient, and as listed above, first, we do no harm. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 10/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(I-22)

Introduced by: Washington

Subject: Advocating for the Informed Consent for Access to Transgender Health Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Transgender and gender-diverse individuals experience several challenges in accessing appropriate health care, including gatekeeping and difficulty with insurance coverage; and

Whereas, Providing gender-affirming care is a medical necessity as determined by the World Professional Association for Transgender Health and supported by the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and several other medical organizations; and

Whereas, Gender-affirming health care improves quality of life, mental health, and overall well-being in gender-diverse people; and

Whereas, Currently, under the mainstream diagnostic model for transgender health, to be deemed eligible for gender transition services, transgender clients must meet criteria for a diagnosis of “gender dysphoria” as described in the DSM-5; and

Whereas, An alternative to that diagnostic model for transgender health is the informed consent model, which allows for clients who are transgender to access hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist; therefore be it

RESOLVED, That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care services.
(Directive to Take Action)

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

Received: 10/10/22

REFERENCES:

1. Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., ... & Baral, S. D. (2016). Global health burden and needs of transgender populations: a review. *The Lancet*, 388(10042), 412-436.
2. Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
3. Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. - World Professional Association for Transgender Health. Accessed December 29, 2021. <https://www.wpath.org/newsroom/medical-necessity-statement>
4. Jellestad, L., Jäggi, T., Corbisiero, S., Schaefer, D. J., Jenewein, J., Schneeberger, A., Kuhn, A., & Garcia Nuñez, D. (2018). Quality of Life in Transitioned Trans Persons: A Retrospective Cross-Sectional Cohort Study. *BioMed research international*, 2018, 8684625. <https://doi.org/10.1155/2018/8684625>
5. Schulz, S. L. (2018). The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria. *Journal of Humanistic Psychology*, 58(1), 72–92. <https://doi.org/10.1177/0022167817745217>

RELEVANT AMA POLICY

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third-party involvement outside of the physician-patient relationship in the decision making process.

Citation: Res. 014, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(I-22)

Introduced by: Medical Student Section

Subject: Guidelines on Chaperones for Sensitive Exams

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Estimates indicate that almost 11 percent of provider misconduct reports are sexual in
2 nature¹; and
3

4 Whereas, Rigorous published studies conclude that we lack sufficient information on
5 malpractice to accurately establish the rates and types of physician misconduct²; and
6

7 Whereas, Medical chaperones are third parties who accompany patients during medical
8 examinations³; and
9

10 Whereas, The presence of medical chaperones is a common practice during sensitive exams
11 for patients^{3,4}; and
12

13 Whereas, Physicians can be reported for alleged misconduct that never occurred, but is difficult
14 to disprove without witnesses⁵; and
15

16 Whereas, University of Michigan policy states that “A chaperone’s presence may also provide
17 protection to health professionals against unfounded allegations of improper behavior, and a
18 health professional should be able request a chaperone for any examination or procedure”⁶; and
19

20 Whereas, A study investigating whether medical chaperones affect patient satisfaction found
21 that 61% of adolescent patients preferred to be offered a chaperone^{3,4}; and
22

23 Whereas, American College of Obstetricians and Gynecologists (ACOG) recommends, in part,
24 accommodating patient requests for a chaperone, regardless of the physician's gender⁷; and
25

26 Whereas, The American College of Physicians Ethics Manual states that “in general, the more
27 intimate the examination, the more the physician is encouraged to offer the presence of a
28 chaperone”⁸; and
29

30 Whereas, Pediatric patients, disabled patients, patients with judgement-altering health
31 conditions, patients who lack the capacity to give informed consent, and patients who are
32 otherwise unable to protect themselves from abuse, neglect or exploitation are vulnerable to
33 potential misconduct and may be unable to request a chaperone; and
34

35 Whereas, Some institutions require formally trained chaperones, including in 7 states which
36 have implemented legal mandates for the presence of medical chaperones during sensitive
37 physical exams⁹⁻¹³; and

1 Whereas, Patients may not want an extra person present for sensitive examinations due to the
2 private nature of such examinations, and thus an opt-in/opt-out policy is preferable to a fully
3 mandated policy¹⁴; and
4

5 Whereas, Documentation of patient interactions has been shown to decrease rates of litigation
6 ruled against providers¹⁵; and
7

8 Whereas, Patients may be uncomfortable requesting a chaperone when the provider asks
9 themselves due to intimidation or fear of undermining the trust in the patient-provider
10 relationship, and a study found that 54% of patients preferred to have the nurse ask about
11 chaperone preference rather than the physician⁵; and
12

13 Whereas, Chaperones may feel uncertain or concerned about intervening during an
14 inappropriate exam or reporting potential misconduct, especially if they are hierarchically inferior
15 to the provider, demonstrating the need to educate chaperones on proper conduct¹³; and
16

17 Whereas, AMA policy states says any authorized member of the health care team can serve as
18 a medical chaperone as long as there are clear expectations to uphold professional standards
19 of privacy and confidentiality, failing to address potential discomfort a chaperone may have in
20 reporting egregious behavior during exams; and
21

22 Whereas, There have been instances of litigation when patient declined a chaperone during an
23 exam¹⁶; and
24

25 Whereas, Physicians may feel uncomfortable performing sensitive exams on patients without a
26 chaperone due to fear of litigation or discomfort with patient conduct during an exam; and
27

28 Whereas, American Association of Family Physicians Policy suggests that providers should not
29 allow the process of ensuring that an exam is chaperoned to interfere with appropriate and
30 timely patient care and clinical judgment; and
31

32 Whereas, AMA and ACOG policy have extensive protection guidelines for patients, but do not
33 include guidelines to protect physicians¹⁷; therefore be it
34

35 RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial
36 Affairs to consider amending E-1.2.4, "Use of Chaperones in Code of Medical Ethics," to ensure
37 that it is most in line with the current best practices and potentially considers the following
38 topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation
39 surrounding the use or not-use of chaperones; c) use of chaperones for patients without
40 capacity; d) asking patients' consent regarding the gender of the chaperons and attempting to
41 accommodate that preference as able. (Directive to Take Action)

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

Received: 10/12/22

References:

1. Arora KS, Douglas S, Dorr Gould S. What brings physicians to disciplinary review? A further subcategorization. *AJOB Empirical Bioethics*. 2014;5(4):53–60.
2. DuBois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: a mixed-methods, exploratory analysis of 101 cases [published online ahead of print June 19, 2017]. *Sex Abus*. 2017.
3. Renee Morgan, MBBS DM, Debra K Katzman, MD FRCPC, Miriam Kaufman, BSN MD FRCPC, Eudice Goldberg, MD FRCPC, Alene Toulany, MD FRCPC, Thanks for asking: Adolescent attitudes and preferences regarding the use of chaperones during physical examinations, *Paediatrics & Child Health*, Volume 21, Issue 4, May 2016, Pages 191–195, <https://doi.org/10.1093/pch/21.4.191>
4. Sinha S, De A, Jones N, Jones M, Williams RJ, Vaughan-Williams E. Patients' attitude towards the use of a chaperone in breast examination. *Ann R Coll Surg Engl*. 2009;91(1):46–49.
5. Segal J. When seeing patients, is three a crowd? *Medscape*. Dec. 2, 2015. <https://www.medscape.com/viewarticle/852865>.
6. Office of Clinical Affairs, University of Michigan Medicine. The Use of Chaperones During Sensitive Examinations and Procedures. <https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures>
7. Committee on Ethics, American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion No. 373: sexual misconduct. *Obstet Gynecol*. 2007;110(2 pt 1):441–444.
8. Snyder L. American College of Physicians Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med*. 2012;156(1 pt 2):73–104.
9. UCLA Health. Medical Chaperones. <https://www.uclahealth.org/body.cfm?id=3569&fr=true>
10. UCLA Health. Preventing Sexual Misconduct. <https://www.uclahealth.org/body.cfm?id=3572&fr=true>
11. Old, S. Best Practice in the Use of Chaperones. *MDU Journal*. April 2014. <https://www.themdu.com/guidance-and-advice/journals/mdu-journal-april-2014/best-practice-in-the-use-of-chaperones>
12. Chaperone Policy. Johns Hopkins Medicine. September 2016. https://www.hopkinsmedicine.org/suburban_hospital/for_physicians/docs/chaperone-policy.pdf
13. Nichols, S. The Importance of Chaperones in a Medical Setting. *Curi Practice Services*. <https://cure.com/news/the-importance-of-chaperones/>
14. Best Practices for Sensitive Exams. ACHA Guidelines. https://www.acha.org/documents/resources/guidelines/ACHA_Best_Practices_for_Sensitive_Exams_October2019.pdf
15. Avoiding Litigation in Clinical Practice *J Indian Assoc Pediatr Surg*. 2019 Jul-Sep; 24(3): 158–161. doi: [10.4103/jiaps.JIAPS_78_19](https://doi.org/10.4103/jiaps.JIAPS_78_19)
16. Segal, J. When Seeing Patients, is Three a Crowd? *Medscape Business of Medicine*. December 2015. <https://www.medscape.com/viewarticle/852865>
17. Sexual Misconduct. ACOG Committee on Ethics. No. 796, Jan 2020. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct>

RELEVANT AMA POLICY

1.2.4 Use of Chaperones

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

Physicians should:

- (a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.
- (b) Always honor a patient's request to have a chaperone.
- (c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
- (d) In general, use a chaperone even when a patient's trusted companion is present.
- (e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

AMA Principles of Medical Ethics: I,IV

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: 013
(I-22)

Introduced by: Medical Student Section

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have
2 undergone a previous cesarean section undergo trial of vaginal birth; and
3

4 Whereas, Many hospitals ban the practice of TOLAC¹⁻³; and
5

6 Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections
7 because women eligible for vaginal birth are not given the opportunity for TOLAC⁴; and
8

9 Whereas, Women may have to travel far distances to find a hospital or provider that is willing to
10 let them attempt TOLAC⁵; and
11

12 Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all
13 United States births in 2017⁶⁻⁸; and
14

15 Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not
16 associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm
17 delivery for future pregnancies⁹; and
18

19 Whereas, Vaginal births result in decreased rates of respiratory distress and other complications
20 for newborns as compared to cesarean section births^{10,11}; and
21

22 Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than
23 elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%¹²; and
24

25 Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection
26 between women undergoing TOLAC versus ERCD¹²; and
27

28 Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000
29 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for
30 women with no contraindications¹³; and
31

32 Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at
33 hospitals that provide at least basic maternal care^{14,15}; and
34

35 Whereas, TOLAC is a viable alternative to cesarean section that should be considered during
36 the antepartum course of care and be part of the physician-patient decision process¹⁶; and
37

38 Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment
39 allows patients control and autonomy over their healthcare decisions; and

Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients^{3,17}; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our American Medical Association encourage hospitals that can provide basic maternal care as defined by the American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC) (New HOD Policy); and be it further

RESOLVED, That our AMA encourage hospitals that do not have resources to perform TOLAC to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC. (New HOD Policy)

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

Received: 10/12/22

References:

1. Rosenstein MG, Norrell L, Altshuler A, Grobman WA, Kaimal AJ, Kuppermann M. Hospital bans on trial of labor after cesarean and antepartum transfer of care. *Birth*. 2019;46(4):574-582. doi:10.1111/birt.12460.
2. Kukura E. Choice in Birth: Preserving Access to VBAC. *Penn State Law Review*. 2010;114(3):955-1001. [http://www.pennstatelawreview.org/articles/114/114 Penn St. L. Rev. 955.pdf](http://www.pennstatelawreview.org/articles/114/114%20Penn%20St.%20L.%20Rev.%20955.pdf). Accessed March 29, 2020.
3. Murphy C. Why Do So Many U.S. Hospitals Prohibit Vaginal Birth After a C-Section? *Elle*. December 2016. <https://www.elle.com/life-love/a41109/vbac-vaginal-birth-after-c-section/>. Accessed March 30, 2020.
4. Rosenstein M, Kuppermann M, Gregorich S, Cheng Y, Caughey A, Barger M. 202: The effect of hospital policy regarding trial of labor after cesarean (TOLAC) on primary cesarean delivery rates over time. *American Journal of Obstetrics and Gynecology*. 2015;212(1). doi:10.1016/j.ajog.2014.10.248.
5. Rosenstein MG, Kuppermann M, Barger MK. 615: In an era of decreased access, how far do women travel for vaginal birth after cesarean (VBAC)? *American Journal of Obstetrics and Gynecology*. 2017;216(1). doi:10.1016/j.ajog.2016.11.349.
6. Betrán AP, Temmerman M, Kingdon C, et al. Interventions to reduce unnecessary caesarean sections in healthy women and babies. *The Lancet*. 2018;392(10155):1358-1368. doi:10.1016/s0140-6736(18)31927-5.
7. Croke LM. Planning for Labor and Vaginal Birth After Cesarean Delivery: Guidelines from the AAFP. *American Family Physician*. <https://www.aafp.org/afp/2015/0201/p197.html>. Published February 1, 2015. Accessed March 3, 2020.
8. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. Births: Final data for 2017. *Natl Vital Stat Rep*. 2018;67(8):1-50.
9. Sandall J, Tribe RM, Avery L, et al. Short-term and long-term effects of caesarean section on the health of women and children. *The Lancet*. 2018;392(10155):1349-1357. doi:10.1016/s0140-6736(18)31930-5.
10. Baumfeld Y, Walfisch A, Wainstock T, et al. Elective cesarean delivery at term and the long-term risk for respiratory morbidity of the offspring. *European Journal of Pediatrics*. 2018;177(11):1653-1659. doi:10.1007/s00431-018-3225-8.
11. Li Y, Zhang C, Zhang D. Cesarean section and the risk of neonatal respiratory distress syndrome: a meta-analysis. *Archives of Gynecology and Obstetrics*. 2019;300(3):503-517. doi:10.1007/s00404-019-05208-7.
12. Dy J, Demeester S, Lipworth H, Barrett J. No. 382-Trial of Labour After Caesarean. *Journal of Obstetrics and Gynaecology Canada*. 2019;41(7):992-1011. doi:10.1016/j.jogc.2018.11.008.
13. Cheng YW, Eden KB, Marshall N, Pereira L, Caughey AB, Guise J-M. Delivery After Prior Cesarean: Maternal Morbidity and Mortality. *Clinics in Perinatology*. 2011;38(2):297-309. doi:10.1016/j.clp.2011.03.012.
14. Practice Bulletin No. 184 Summary: Vaginal Birth After Cesarean Delivery. *Obstetrics & Gynecology*. 2017;130(5):1167-1169. doi:10.1097/00006250-201711000-00045.
15. Levels of Maternal Care. American College of Obstetricians and Gynecologists. <https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Levels-of-Maternal-Care>. Published July 25, 2019. Accessed March 5, 2020.
16. Attanasio LB, Kozhimannil KB, Kjerulff KH. Womens preference for vaginal birth after a first delivery by cesarean. *Birth*. 2018;46(1):51-60. doi:10.1111/birt.12386.
17. Enking M. After a C-section, women who want a vaginal birth may struggle to find care. *PBS News Hour Weekend*. <https://www.pbs.org/newshour/health/c-section-vbac-vaginal-maternal-health>. Published August 12, 2018. Accessed March 29, 2020.

RELEVANT AMA POLICY

Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

[AMA Principles of Medical Ethics: I,II,IV,VIII](#)

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

Code of Medical Ethics Opinion 1.1.3 Patient Rights

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

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.
- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without

giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

[AMA Principles of Medical Ethics: I,IV,V,VIII,IX](#)

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

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives. Res. 23, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Shared Decision-Making H-373.997

Our AMA:

1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.

CMS Rep. 7, A-10. Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmed: CMS Rep. 06, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(I-22)

Introduced by: Washington

Subject: Restricting Derogatory and Stigmatizing Language of ICD-10 Codes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, LGBTQI+ individuals, particularly our transgender patients, face high levels of stigma
2 and discrimination; and
3

4 Whereas, Transgender individuals experience several challenges in accessing appropriate
5 health care and encounter difficulties with insurance coverage; and
6

7 Whereas, Requiring a diagnosis with stigmatizing language may further restrict and harm
8 LGBTQI+ patients attempting to access inclusive health care, such as gender-affirming
9 hormonal therapy and preexposure prophylaxis, to lower the risk of acquiring HIV; and
10

11 Whereas, There are few if any diagnosis codes without stigmatizing language in ICD-10
12 accepted by insurance companies to cover certain services, such as gender-affirming health
13 care and preexposure prophylaxis for human immunodeficiency syndrome; therefore be it
14

15 RESOLVED, That our American Medical Association collaborate with the World Health
16 Organization to implement destigmatizing terminology in ICD-10 that will cover gender-affirming
17 health care services as well as human immunodeficiency virus pre-exposure prophylaxis
18 services and medications. (Directive to Take Action)

Fiscal Note: Minimal – less than \$1,000

Received: 10/10/22

RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19