DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-23)

Report of Reference Committee on Amendments to Constitution and Bylaws

Po-Yin Samuel Huang, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 01 – Employed Physicians
2. BOT Report 10 - Medical Decision-Making Autonomy of the Attending Physician
3. BOT Report 17 - Specialty Society Representation in the House of Delegates—Five-Year Review
4. Resolution 006 - Inappropriate Use of Health Records in Criminal Proceedings

RECOMMENDED FOR ADOPTION AS AMENDED

5. Resolution 002 – Support for International Aid for Reproductive Health
6. Resolution 007- Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
7. Resolution 004 – Reconsideration of Medical Aid in Dying (MAID)

RECOMMENDED FOR REFERRAL

8. CEJA Report 01 - Physicians' Use of Social Media for Product Promotion and Compensation
9. CEJA Report 02 - Research Handling of De-Identified Patient Data
10. Resolution 009 - Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests

RECOMMENDED FOR NOT ADOPTION

11. Resolution 005 – Adopting a Neutral Stance on Medical Aid in Dying

Amendments

If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 01 – EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Board of Trustees Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees report 01 adopted and the remainder of the Report be filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of the recommendations of BOT Report 09-I-22 and that the remainder of this report be filed:

That our AMA re-examine the representation of employed physicians within the organization and report back at the 2024 Annual Meeting.

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that BOT Report 01 be adopted.

(2) BOARD OF TRUSTEES REPORT 10 – MEDICAL DECISION-MAKING AUTONOMY OF THE ATTENDING PHYSICIAN

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Board of Trustees Report 10 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 10 adopted and remainder of the Report filed.

In light of the foregoing, your Board of Trustees recommends that the:
1. First, second, and third resolve clauses of Resolution 009-I-22, “Medical Decision-Making Autonomy of the Attending Physician” not be adopted; and
2. Fourth resolve clause of Resolution 009-I-22 be adopted with amendment as follows:

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

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that BOT Report 10 be adopted.

(3) BOARD OF TRUSTEES REPORT 17 – SPECIALITY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES-FIVE YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that recommendations in the Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Board of Trustees Report 17 adopted and the remainder of the Report be filed.

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

1. The American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology—Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, and Society of Nuclear Medicine and Molecular Imaging retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

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

Testimony was heard in unanimous support. Your Reference Committee recommends that BOT Report 17 be adopted.

(4) RESOLUTION 006 – INAPPROPRIATE USE OF HEALTH RECORDS IN CRIMINAL PROCEEDINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 006 be <u>adopted.</u>

HOD ACTION: Resolution 006 <u>adopted</u>

RESOLVED, that our American Medical Association encourage collaboration with relevant parties, including state and county medical societies, the American College of Correctional Physicians, and the American Bar Association, on efforts to preserve patients' rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care. (New HOD Policy)

Testimony was heard in unanimous support. Your Reference Committee recommends that Resolution 006 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(5) RESOLUTION 002 – SUPPORT FOR INTERNATIONAL AID FOR REPRODUCTIVE HEALTH

RECOMMENDATION A:

That the first resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations ~~which~~ solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy); and it be further

RECOMMENDATION B:

That the second resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our AMA supports funding for global humanitarian and non-governmental organizations ~~assistance~~ for maternal healthcare comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 002 be adopted as amended.

HOD ACTION: Resolution 002 adopted as amended.

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy); and it be further

RESOLVED, that our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy)

Testimony was generally supportive including for a proffered amendment. Testimony cited the need to support our physicians who practice globally and

that the recommendation aligns with existing policy. Your Reference Committee recommends that Resolution 002 be adopted as amended.

(6) RESOLUTION 007 – IMPROVING ACCESS TO FORENSIC MEDICAL EVALUATIONS AND LEGAL REPRESENTATION FOR ASYLUM SEEKERS

RECOMMENDATION A:

That Resolution 007 be amended by deletion as follows:

~~RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further~~

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources~~, including, but not limited to, the Asylum Medicine Training Initiative~~. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 007 be adopted as amended.

HOD ACTION: Resolution 007 referred.

RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative. (New HOD Policy)

Testimony was mixed. There were concerns raised about the first resolve clause because it was outside the purview of the AMA. Online testimony suggested amendment by deletion of specific reference to “Asylum Medicine Training Initiative” to avoid specific program references. Your Reference Committee recommends that Resolution 007 be adopted as amended.

(7) RESOLUTION 004 – RECONSIDERATION OF MEDICAL AID IN DYING (MAID)

RECOMMENDATION A:

That Resolution 004 <u>be amended by deletion.</u>

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

~~**RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions**~~ **(New HOD Policy)**

~~**RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue**~~ **(Rescind HOD Policy)**

RECOMENDATION B:

Your Reference Committee recommends that alternative Resolve 4 be adopted in lieu of current Resolve 4:

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
Decisions Near the End of Life, H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia ~~or participate in assisted suicide~~. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia ~~and assisted suicide.~~ In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia ~~or physician-assisted suicide~~ at this time.
(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that the fifth Resolve of 004 be referred.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 004 be adopted as amended.

RECOMMENDATION E:

Your Reference Committee recommends a title change to Resolution 004 to read as follows:

STUDY OF PHYSICIAN ASSISTED SUICIDE AND MEDICAL AID IN DYING

HOD ACTION: First Resolve of Resolution 004 amended by addition and deletion as follows:

~~RESOLVED, that our American Medical Association oppose criminalization of~~

~~**physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further**~~

RESOLVED, that our AMA oppose criminal or civil legal action against physicians and health professionals who engage, or attempt to engage in providing a lethal dose of medication for terminally ill patients to use at such time as the patient sees fit, and oppose civil or criminal legal action against patients for using medications prescribed with this intent; and be it further

RESOLVED, that our AMA study alternative terminology such as "End of Life Expanded Treatment Options" rather than either the term "Physician Assisted Suicide" or "Medical Aid in Dying", both of which have historically been considered objectionable by various groups of physicians and are therefore divisive.

HOD Action: Amended Resolution 004 referred.

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions (New HOD Policy)

RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue (Rescind HOD Policy)

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
Decisions Near the End of Life, H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves

to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~
(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal. (Directive to Take Action)

Mixed testimony was heard, with a significant amount of testimony both in support and in opposition.

Your Reference Committee heard mixed but supportive testimony for resolve 1 to protect physicians from criminalization and did not hear any direct opposition to this resolve. Therefore, your Reference Committee recommends adoption of resolve 1.
Your Reference Committee heard impassioned but mixed testimony regarding resolves 2 through 5. Therefore, your Reference Committee thinks further study is warranted and is recommending referral of resolve 5 so that this may be accomplished. Until this study can be concluded, your Reference Committee recommends resolves 2 and 3 not be adopted and alternative resolve 4 be adopted until evidence-based information can be evaluated. Therefore, your Reference Committee recommends Resolution 004 be adopted as amended with a title change.

RECOMMENDATION FOR REFERAL

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 01 – PHYSICIANS' USE OF SOCIAL MEDIA
FOR PRODUCT PROMOTION AND COMPENSATION

RECOMMENDATION:

Your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 01 be referred back to CEJA.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 01 referred back to CEJA.

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

Opinion 9.6.4, "Sale of Health-Related Products," and Opinion 9.6.5, "Sale of Non-Health-Related Products" be consolidated and amended by substitution to read as follows:

The sale or promotion of products or services by physicians may offer benefit to patients or the public but may also conflict with their professional ethical responsibilities. Whether intended or not, they may be perceived to use their professional knowledge and stature as inducements to consumers. There are four key scenarios of sales or promotion: (1) health-related products or services marketed to patients, (2) health-related products or services marketed to the general public, (3) non-health-related product or services marketed to patients, and (4) non-health-related products or services marketed to the general public.

Of greatest concern are commercial practices in which physicians sell or promote goods or services to patients. In these circumstances patients may feel pressured to purchase the product or service, which may compromise the physician's fiduciary obligation to put patients' interests above their own financial interests and undermine the trust that grounds patient-physician relationships. Similarly, if physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable value they may put patient well-being and the integrity of the profession in jeopardy.

Physicians and medical students therefore should:

Refrain from leveraging their professional role to promote unrelated business ventures.

Fully disclose the nature of their financial interest in the product or service.

Avoid exclusive distributorship arrangements that make products or services available only through the individual's commercial venue.

Limit the sale or promotion of health-related goods or services only to those that serve the immediate needs of patients and strive to make the product or service available at a reasonable cost.

Refrain from the sale or promotion of non-health-related goods or services as a regular part of their professional activities. (Modify HOD/CEJA Policy); and

2. Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as follows: Social media—internet-enabled communication technologies—enable individual medical students and physicians to have both a personal and a professional presence online.
Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to disseminate public health messages and other health communication widely. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.
Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:
Use caution when publishing any content that could damage their individual professional reputation or impugn the integrity of the profession.
(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing identifiable patient information online. When they use social media for educational purposes or to exchange information professionally with other physicians or medical students they should follow ethics guidance regarding confidentiality, privacy, and informed consent.
(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with patients through social media, just as they would in any other context.
(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.
Disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.
(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate. They should likewise ensure to the best of their ability that non-health-related information is not deceptive. (Modify HOD/CEJA Policy); and
3. The remainder of this report be filed.

Testimony was mixed, but the majority supported referral. Testimony in support suggested that these were appropriate recommendations that do not actually prohibit physicians from offering products for sale but instead offer suitable guidelines concerning how to do so in an ethical manner. Testimony in opposition asked CEJA to reconsider recommendations concerning exclusive distributorship since these might negatively affect innovation. It was suggested that the language requiring that products meet the "immediate” needs of patients should be changed to include long-term healthcare needs as well. Some testimony pointed out that there are practice models in place that would be restricted by these recommendations, and that since reimbursement is declining, it is a benefit to practices to be able to sell products to offset costs. It was also noted that the recommendations concerning the use of social media for educational purposes

seem to imply that informed consent is required in that context even when it is not possible to obtain it. Your Reference Committee recommends that CEJA Report 01 be referred.

(9) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 02 – RESEARCH HANDLING OF DE-IDENTIFIED PATIENT DATA

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Council on Ethical and Judicial Affairs Report 02 be referred back to CEJA.

HOD ACTION: Recommendations in Council on Ethical and Judicial and Ethical and Judicial Affairs Report 02 referred back to CEJA.

In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:

1. That the following be adopted:

Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health. When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy;
(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets;
(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with HIPAA (or current legal standards).

Health care systems, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:
(d)The high value that health care institutions place on protecting patient data;
(e)The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist;
(f)How patient data may be used and by whom;
(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care systems, as health data stewards, should:

(h) Establish appropriate data collection methods and practices that meet industry standards to ensure the creation of high-quality datasets;
(i) Ensure proper oversight of patient data is in place, including provisions for the use of de-identified datasets that may be shared, sold, or resold;
(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest to evaluate the sale and potential resale of clinically-derived datasets;
(k) Take appropriate cyber security measures to ensure the highest level of protection is provided to patients and patient data;
(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients;
(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and

2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2, "Confidentiality and Electronic Medical Records" be amended by addition as follows:

a. Opinion 2.1.1, Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. <u>Transparency with patients regarding all options of treatment is critical to establishing trust and should extend to discussions regarding who has access to patients' health data and how data may be used.</u>
The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the

patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)

b. Opinion 3.1.1, Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).
Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:
(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.
<u>(d) Be transparent that privacy safeguards for patient data are in place but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)</u>

c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.
Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.
Physicians who propose to permit third parties to access the patient's full medical record should:
(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.
(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.
Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to ensure that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)
d. Opinion 3.3.2, Confidentiality and Electronic Medical Records
Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.
Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:
(a) Choose a system that conforms to acceptable industry practices and standards with respect to:
(i) restriction of data entry and access to authorized personnel;
(ii) capacity to routinely monitor/audit access to records;
(iii) measures to ensure data security and integrity; and
(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.
(b) Describe how the confidentiality and integrity of information is protected if the patient requests.
(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and
3. That the remainder of this report be filed.

Testimony was overwhelmingly in support of referral. Testimony cited that the topic was important but that issues related to informed consent, language regarding "all options" as opposed to "medically appropriate" options, and language regarding the use of "ensure" need to be reassessed. It was also noted that physicians cannot "ensure" that data is used only in certain ways, since they are not in control of what happens to it at the systems level. Some testimony opposed the claim that patients have a responsibility or duty to provide their data for the purposes of public health, instead maintaining that this was not obligatory but they could freely volunteer if they wished. Some testimony also indicated that guidelines for the sale of patient data implied that such sales are permissible when in reality they are a violation of confidentiality. It was asked that the recommendations be revised to include some discussion of exclusive contracts for data sharing that may inhibit innovation across whole areas of specialty. Your Reference Committee recommends that CEJA Report 02 be referred.

(10) RESOLUTION 009 – PHYSICIANS ARRESTED FOR NON-VIOLENT CRIMES WHILE ENGAGED IN PUBLIC PROTESTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be referred.

HOD ACTION: Resolution 009 referred.

RESOLVED, that our American Medical Association advocate to appropriate credentialing organizations and payers—including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of health care goods and services—that misdemeanor or felony arrests of physicians as a result of exercising their First Amendment rights of protest through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)

Testimony was mixed. Testimony suggested that advocating for patients requires the ability to participate in nonviolent protests, and those who do so may find themselves arrested and so face negative implications for their careers. Further, testimony pointed out that the resolution only discusses arrests and not convictions, and this distinction should be recognized. Testimony highlighted the inconsistency in the severity of charges for the same activities in different jurisdictions. Opposing testimony recommended referral because the recommendation is overly broad and could allow those who spread medical disinformation or falsely pose as reproductive health providers to be protected from professional consequences. It was further noted that felonies maybe different from misdemeanors and so the recommendations should be omitted that suggest they are to be treated in an equivalent manner. Online testimony proffered an amendment to add “employers” to the list entities. Your Reference Committee recommends that Resolution 009 be referred.

RECOMMENDED FOR NOT ADOPTION

(11) RESOLUTION 005 – ADOPTING A NEUTRAL STANCE ON MEDIAL AID IN DYING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 005 be <u>not adopted.</u>

HOD ACTION: Resolution 005 <u>not adopted.</u>

RESOLVED, that our American Medical Association adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter. (New HOD Policy)

Resolution 005 was considered at the same time as Resolution 004. As stated previously, your Reference Committee heard extensive but mixed testimony on this topic. Therefore, Your Reference Committee has recommended in Resolution 004 that this issue be further studied. Your Reference Committee recommends that Resolution 005 be not adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Dr. Joseph Adashek, Dr. Kenneth Andreoni, Dr. Cee Davis, Dr. Lisa Hatcher, Dr. Tate Hinkle, and Dr. Elana Sitnik and all those who testified before the committee.

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Nevada State Medical Association

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