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REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-I-25

Subject: Addressing the Unregulated Body Brokerage Industry

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2024 Interim Meeting, Resolution 212, "Addressing the Unregulated Body Brokerage Industry," was introduced by Illinois and was referred. It asked the following:

> RESOLVED, that our American Medical Association amend existing policy H-460.890, Improving Body Donation Regulation,"[1] by addition to read as follows:
>
> Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations.; (2) will collaborate with interested organizations to actively advocate for the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

BACKGROUND

Body-brokers are individuals or businesses who procure bodies through soliciting donations (usually at funeral homes and hospices) and then sell or lease the donated bodies or parts of the body to other entities for a variety of purposes. Brokers will typically sell a body for $3,000 to $5,000; however, bodies have been sold for upwards of $10,000. Individual body parts are sold for a range of prices, e.g., "$350 for a foot, $300 for a spine."[2] The clients of body brokers include emergency services such as fire departments and paramedics, medical schools, medical researchers, and the military.[3]

In recent years, the body-brokerage industry has come under increased scrutiny due to claims that the autonomy and dignity of the person who donated their body was not respected or upheld. For example, in 2021, the body of a man who died of COVID-19, which was donated to a body-broker, was used in a "Cadaver Class" where people could pay money to see a live autopsy performed.[4] The family of the man was furious when they found out his body was used in this public way for monetary gain and asserted that the transaction was a breach of informed consent.[4] In another incident, a man who donated his mother's body for use in medical research sued a body-broker because her body was instead used to test "bomb impact" in experiments conducted by the U.S. Army.[5]

Notably, the industry is one whose "business model hinges on access to a large supply of free bodies, which often come from the poor." Brokers often offer "free cremation" in exchange for access to bodies as a way to appeal to "low-income families at their most vulnerable".[2] Those whose bodies go unclaimed often have their bodies sold to body-brokers without consent. For example, the unclaimed body of a veteran in Texas who "was entitled to a burial with military honors", was instead sold by the county medical examiner's office to a broker without the man's consent or his family's knowledge. Subsequently, the man's body was "cut into pieces and leased out across the country."[6] Critics, like Angela McArthur from the University of Minnesota Medical School, have likened the body-brokerage industry to a "free-for-all" and have stated that brokers are similar to "grave-robbers" of the 19th-century who are "profiting from the sale of humans."[2] It is against this backdrop that serious ethical concerns have been illuminated and have increased the demand for greater industry regulation.

DISCUSSION

Despite major ethical concerns, the legal landscape does not adequately address concerns of bodies being used in ways in which the donator did not consent. Importantly, there are no federal laws governing the sale of cadavers or body parts for use in research or education and few state laws provide adequate oversight.[2] The most common statutory guidance resides in the Uniform Anatomical Gift Act (UAGA), a model law adopted by the majority of states which "allows a descendant or surviving relatives to donate certain parts of the decedent's organs for certain purposes", i.e., organ donation or medical research.[11] The UAGA states that an anatomical gift can be made to a "university; organ procurement organization; or other appropriate person for research or education." However, the scope of who is deemed an "appropriate person for research or education" is left undefined. The result of this ambiguity is that any "commercial entity may obtain a donated body so long as they use it in some form of activity that is considered educational or research oriented." In many cases, the educational or research purpose is dubious or of minimal value.[12]

In response to the lack of legal oversight, the National Funeral Directors Association is supporting a bill they dub the "Body Broker Bill", officially known as the Consensual Donation & Research Integrity Act of 2025, which has been introduced in Congress but has not yet passed.[13,14] The bill claims to "protect the dignity of donors and give families peace of mind by creating standards for inspection; chain of custody; labeling and packaging; and proper disposition."[13] While the Body Broker Bill takes an important step toward regulating the industry, the bill is not as comprehensive as recent best practice guidance and standards on human body donation from the American Association for Anatomy (AAA).[15] The AAA guidelines call for body donation policies to include a mandatory standard for informed consent and outline core operational practices intended to ensure transparency and accountability during every aspect of the body donation process that are more ethically rigorous than those included in the Body Broker Bill. For example, the AAA advises against body part solicitation from terminal patients in hospitals or hospice care and that documentation be secured to ensure that all uses match the donation consent agreement.

Lastly, the for-profit acquisition and sale of donated human bodies and body parts for research and education also creates ethical concerns. While neither the UAGA nor Body Broker Bill prohibit the sale of body parts for profit, AAA best practices recommend that body donation should operate on a non-for-profit model. However, regardless of the financial model used, it is crucial to address the ethical concerns surrounding the body-brokerage industry by establishing stronger legal protections to ensure oversight and ethical accountability. While the resolution called for development of model state legislation, to most efficiently address these issues in upcoming state legislative sessions, the AAA policy guidelines should be utilized to guide advocacy.

CONCLUSION

Although the body broker industry has faced scrutiny, the industry does provide a necessary service which benefits both medical research and education. However, despite its necessity, the body brokerage industry must operate in an ethical and transparent manner.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 212-I-24 and the remainder of the report be filed.

1. That Policy H-460.890, Improving Body Donation Regulation," be amended by addition and deletion as follows:

   1. Our AMA recognizes the need for ethical, and transparent~~,~~ regulations for body and body part donation ~~regulations~~ consistent with body donation best practices including:

      a. *Outreach:* This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.

      b. *Registration:* A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e., military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.

      c. *Custody:* A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g., researchers, educators, clinicians).

      d. *Tracking:* A tracking system should be put in place to ensure the proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

      e. *Use:* Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.

      f. *Disposition:* Final disposition of the body should be made in accordance with the wishes of the donor and their families.

      g. *Memorialization:* A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

2. Supports federal and state legislation consistent with body donation best practices that require all body donation programs adopt and implement policies which uphold informed consent, transparency, and accountability during the process of human body donation and use.

3. Encourages state medical societies to advocate for legislation consistent with body donation best practices. (Modify Current HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-25

Subject: On the Ethics of Human Lifespan Prolongation

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2024 Interim Meeting, the House of Delegates (HOD) adopted policy D-140.947, "On the Ethics of Human Lifespan Prolongation," which directs our AMA to:

> undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges.

This report provides background and ethical analysis in fulfillment of the directive.

BACKGROUND

Investment in longevity research has surged in recent years, increasing from half of a billion dollars in 2013 to $6.2 billion in 2021.[1] This longevity market includes not only longevity biotech firms and startups, but also regenerative medicine providers, AI-driven drug discovery platforms, biomarker discovery and diagnostic platforms, and novel therapeutic technologies, such as stem cell-, gene-, and immunotherapy. These technologies are often aimed at ultimately improving the human lifespan and healthspan. While life expectancy is a statistical measure of the average years of life someone can expect to live, the human lifespan refers to the maximum length of life a person can potentially achieve, while healthspan refers to the portion of life a person spends in a healthy state free of chronic diseases and disability. The interdisciplinary field of research dedicated to studying the biological mechanisms of aging and how they contribute to age-related diseases is known as geroscience.[2]

With the advent of modern medicine, life expectancy has nearly doubled in the U.S. since 1900, reaching an average of approximately 78.4 years in 2023.[2,3] Unlike life expectancy, the human lifespan appears to be biologically fixed, with a ceiling around 125 years.[4] However, some people believe that this biological limit can be overcome. Often referred to as radical life extension, some adherents believe that the human lifespan might someday be extended to 150 years, 300 years, or even thousands of years.[4] Importantly, a central goal of radical life extension is to increase not only the human lifespan but also the human healthspan. In the U.S., the lifespan-healthspan gap has been increasing over the past two decades, meaning that while life expectancy has increased, there has also been growth in the number of years people live impacted by chronic disease or disability.[5] Successful radical life extension would thus enable humans to live beyond their current biological limits and do so while experiencing optimal health.

Proponents of radical life extension often view disease, aging, and even death as obstacles to overcome, and argue that such technologies will ease human suffering and drive innovations in

disease prevention and treatment.[2] Opponents typically cite concerns regarding demographics and sustainability, questions of equitable access and social justice, and fears of negative social impacts as views on aging and death change.[4,6,7] Because the technology for radical life extension is still hypothetical, any ethical analysis and debate is inherently speculative; however, as the possibility of such technology increasingly moves from the realm of science fiction to scientific reality, it is important that ethical guidance related to its development, clinical use, and regulation be established.

ETHICS ANALYSIS & DISCUSSION

Achieving radical life extension technologies would be a monumental scientific breakthrough with dramatic impacts. The potential to eradicate chronic diseases and disability while also extending lifespans would represent an enormous reduction in human harm and illness. However, the development of such technologies also has the potential to drastically increase existing inequalities and destabilize existing social norms. Much of the ethical debate regarding whether radical life extension technologies should be developed utilizes a utilitarian approach, arguing that only if the benefits to society are greater than the harms should such innovations be pursued.[8,9]

Aging as a Disease & the Scope of Biomedical Research

Proponents of radical life extension advocate a certain pathologization of aging, representing it as a disease that should be treated. In contrast, critics typically represent aging as a natural part of human life and argue that biomedical interventions should focus on shrinking the human healthspan-lifespan gap rather than on increasing longevity.[6,9] Currently, the Food and Drug Association (FDA) considers aging a natural process and does not recognize aging as a disease, which makes it difficult to get FDA approval for drugs that specifically target aging.[10] However, researchers have found ways to still pursue studies of geroscience. For example, Metformin, an FDA-approved first-line treatment for type 2 diabetes, is also being investigated for its potential not to delay aging specifically but to delay the onset of age-related diseases.[11] If current trials are successful, it could lead to a paradigm shift in how aging is recognized by the FDA and pave the way for the approval of drugs that directly target aging and not just individual diseases. The World Health Organization (WHO) has already begun to move in this direction with regard to the deterioration associated with aging, implying that againg is a disease by including “aging associated decline in intrinsic capacity” as a disease code in their 11th edition of the International Classification of Diseases (ICD).[10] As scientific pressure grows in the US, the FDA is likely to revisit the issue and reevaluate their stance towards aging. If the FDA does change its position, however, the question will remain whether (and how much) funding for clinical research should be diverted from other pursuits towards studies on how to slow or prevent aging.

Equality of Access and Social Justice

A primary ethical concern regarding radical life extension is the possibility that it would exacerbate inequality.[9,12,13] Critics argue that radical life extension technologies would be unethical if they were only available to wealthy individuals. In this view, because such technologies would likely be quite expensive, at least initially, only some members of society would be able to benefit from them.[12] Additionally, there is concern that a focus on longevity technologies would tie up limited resources for improving health in other domains and, as a result, other issues that impact health would be ignored (such as education, pollution, and climate change).[14] Opponents also claim that health research should focus on closing current healthspan-lifespan gaps, rather than on increasing human longevity.[15] On the other hand, proponents argue that combating aging may in fact be far

more cost-effective because aging is the most significant risk factor for disability and most prevalent chronic diseases. They also suggest that while radical life extension technologies are likely to be expensive and not widely available to everyone at first, there is no reason to believe that this situation would persist for long.[9] Some even advocate that, eventually, everyone globally should have access to any interventions that promote healthy aging regardless of socio-economic status.[9]

When weighing the benefits and burdens of radical life extension, the question becomes one of equity, and more specifically, how much social inequality society is willing to accept. There is general agreement that developing longevity technologies would be unethical if doing so greatly increased inequalities over a long period of time, creating two castes of people (those who can access such technologies and those who cannot). However, there is less agreement regarding whether increasing inequalities in the immediate would be unethical if the long-term results were that everyone benefited and lived longer, healthier lives.

Demographic and Resource Concerns

Another important ethical concern has to do with the demographic implications of people living longer. If people die less frequently, populations are likely to grow larger, resulting in a society that consists of an older populous.[15] Increased longevity could also result in longer reproductive years and lead to people having more children. This jump in population could in turn place an unsustainable strain on available resources.[4] Alternatively, some critics have voiced concerns that radially extending life might result in a decreased sense of purpose and thus lead to reductions in social commitments and engagement, eventually leading to decreases in childbearing and reproduction.[7]

Changing Social Values and Norms

Concerns regarding the demographic impact of radical life extension highlight the fact that such innovations would initiate radical social changes. The potential impacts on social values and norms are perhaps the most common yet most amorphous ethical concerns. If radical life extension were to be achieved, it would mean a collision of far more generations than exists in parallel today, which could lead to generational divides and contentions over status and social roles.[6] A rising share of older voters could lead to growing political tensions, as policies favoring the young shift to policies that favor the old.[16] Alternatively, extending the years of youth could lead to a devaluation of the elderly as fundamentally inadequate or defective.[12,14] These tensions could be exacerbated if a generation feels that there is no need to make room for younger generations. Other concerns include fears that radical life extension would diminish the sacredness of life;[4] that altering the human lifespan beyond its biological limits would represent a reconstruction of what it means to be human;[17] and that the slowing of successive generational cycles could lead to the slowing of cycles of innovation and adaptation.[7]

CONCLUSION

Because research on radical life extension is currently situated within a capitalist enterprise, longevity projects and issues of inequality are inherently interconnected.[12] Moreover, the possibility of radical life extension has attracted heavy involvement by the ultra-wealthy, including Larry Page (cofounder of Google) and Jeff Bezos (Amazon's founder), both of whom have significantly invested in longevity research (conducted by Calico Labs and Altos Labs, respectively).[14] Such investments have raised concerns that should these technologies prove

successful, they will only be accessible to a select few and will fuel an ever increasing social divide. If radical life extension were achieved, it would also require significant changes within society to ensure that the future elderly are as healthy and as supported as possible. There would also be a need to ensure that social institutions such as education, jobs, health insurance, and social security are able to support the longer lives of the young.[16]

If radical life extension becomes a reality, society is likely to be divided into the Haves (those who extend their lives), the Have-nots (those who would like to but can't afford to extend their lives), and the Will-nots (those who refuse to extend their lives). Proponents view that in this dynamic, so long as the harms to the Have-nots and the Will-nots are minimal, the significant benefits to the Haves justify pursuit of radical life extension.[8] The argument in favor hinges on the belief that it is always ethical to seek to alleviate suffering and improve the human condition, and this is exactly what radical life extension would achieve.[7] However, this still does not address issues of equity; for radical life extension to be ethical, the medical treatments must be made available to every person and distributed equitably across the globe.[4] What this would look like in practice, however, and how much inequity is socially acceptable in pursuit of radical life extension, is still up for debate.

Due to the currently hypothetical nature of radical life extension technology, developing specific guidelines or regulations at this time presents a challenge, as the technology itself and any impacts it may have remain purely theoretical. However, as is the case with any emerging medical technology, all research on radical life extension should adhere to the appropriate ethical standards set forth by the AMA *Code of Medical Ethics* and the research ethics outlined in the World Medical Association's Declaration of Helsinki. Furthermore, regardless of the form such technology may take or the duration of extended life it may grant, radical life extension, if it were to become a reality, should be made accessible in an ethical, equitable, and just manner.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-140.947 be rescinded as having been accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal – less than $500

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REPORT OF THE BOARD OF TRUSTEES 10 (I-25)
Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
(Reference Committee E&B)

EXECUTIVE SUMMARY

At the 2024 American Medical Association (AMA) Interim Meeting, Resolution 004, "Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients", was introduced by the LGBTQ Section and referred for report back at the 2025 Interim Meeting. The resolution directs the promotion of inclusive gender, sex, and sexual orientation options on medical documentation and proposes amendments to Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation", to recommend broader reforms to EHR systems to better serve transgender and gender-diverse individuals.

This report provides detailed information about efforts taken and challenges presented by the AMA, physicians, practices, EHR vendors, and other stakeholders to address the needs of transgender and gender-diverse individuals. This includes the following considerations:

1. Linking cancer screenings and preventive services to a patient's current anatomical inventory reduces the risk of care gaps. This approach builds on Health Level 7 standards that distinguish "Sex for Clinical Use" from legal sex and gender identity, which is already supported in many EHRs.
2. Gaps exist in how health information technology vendors handle gender and sex data and work collaboratively to ensure systems treat all patients equitably. Structured and standardized fields for sexual orientation and gender identity (SOGI) and organ data are necessary for both research and patient safety.
3. Leveraging personal health records may ease the documentation burden on physicians by allowing patients to input and manage aspects of their identity data directly, so long as interoperability and privacy safeguards are in place.
4. Gender-inclusive data capabilities in EHR systems must be implemented at no added cost to providers, aligning with broader health equity goals without increasing administrative strain.
5. Patient data collection must be opt-in and based on informed consent. Patients should have the ability to opt out without compromising access to care or services. This is especially critical given privacy concerns and legal inconsistencies across states.

Further collection of gender-affirming care data risks exposing patients, families, and physicians to civil liability and criminal prosecution, as current EHRs lack reliable data segmentation and may inadvertently disclose information in states where such care is banned. This report underscores a growing consensus that inclusive EHR documentation enhances clinical safety and patient well-being, while also raising privacy concerns. Despite expanded SOGI and organ inventory fields in EHRs, usage and training remain inconsistent. The report recommends not adopting Resolution 004 (I-24) but supporting the use of "chosen name" over "preferred name"; reaffirming Policy H-315.967; and engaging relevant stakeholders to improve EHR usability for this patient population with strong privacy protections and ensure respectful and up-to-date AMA terminology.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-25

Subject: Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

INTRODUCTION

At the 2024 Interim meeting of the American Medical Association (AMA) the House of Delegates (HOD), Resolution 004, "Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients," was referred for report back at the Interim 2025 meeting. This resolution was introduced by the LGBTQ Section and called for the following:

> RESOLVED, that our American Medical Association amend Policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:
>
> **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967**
>
> Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen 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, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). 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~~4) 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~~5) 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~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender diverse patients (New HOD Policy).

While testimony on this resolution was mostly supportive, there were concerns about terminology and minors' privacy.

This report seeks to advance proposals aligned with best practices for inclusive health documentation, including adoption of the term, "chosen name", and the development of an organ inventory within EHRs—documenting both a patient's medical transition history and current present organs—to ensure anatomically appropriate preventive care, screenings, and treatment. Building on these priorities, the report emphasizes the importance of ensuring that transgender and gender-diverse patients' chosen names are visible across health records, while also acknowledging the challenges to adopting the resolution given the current health care information technology (IT) and political landscape. It further highlights the need for inclusive and standardized data collection practices, equitable treatment in health care technology systems, and expanded use of personal health records to reduce the administrative burden on physicians.

BACKGROUND

Sexual orientation and gender identity (SOGI) data is information collected by health care organizations about a person's sexual orientation and gender identity to help providers and researchers better understand gender-diverse patients, enable culturally-responsive, patient-centered care, and monitor and improve access to quality care.[1] The AMA supports the voluntary, culturally sensitive inclusion of patient data on sex, gender identity, and sexual orientation in medical records[2,3], and is committed to equitable, inclusive care for transgender and gender-diverse patients. In medical contexts, the terminology used to refer to transgender patients' names carries significant weight. Specifically, the term "chosen name" is preferred over "preferred name" due to its affirmation of identity and the mental health benefits associated with its use.[4] Policy H-315.967 underscores the idea of informed consent, including transparent discussions on who can access a patient's data and how it will be used, extending beyond clinical interventions to data privacy and sharing policies. Focus groups revealed that transgender patients appreciated two-step gender identity questions in EHRs, but expressed concern about privacy and desired greater control, including opt-out options, especially in contexts where data might be shared.[5] Guidance on collecting sexual orientation and gender identity emphasizes offering an opt-out ("Choose not to disclose") option.[6] Patients must be informed about why data is collected, how it will be used, and that refusal will not affect their treatment. A recent study showed that patients of sexual and gender minority expect informed consent before capturing SOGI data, prefer to choose when and how to share it, and are more comfortable when staff understand its relevance and patients have the option to decline.[7]

The term “clinical sex” goes beyond a medically convenient label; it’s a contextual, biologically informed data element designed to ensure precise, safe, and inclusive health care. It is important to recognize that ongoing efforts have aimed to make EHRs more inclusive and clinically relevant by bridging the gap between patient identity, clinical accuracy, and respectful care. Sex for Clinical Use (SFCU) and Sex Parameter for Clinical Use (SPCU) are standardized health data elements that captures the sex classification most relevant to a specific clinical context (e.g., lab reference ranges, imaging studies, and medication dosing), as defined by the Health Level 7 (HL7) Gender Harmony Project.[8] SFCU/SPCU reflects the biological characteristics relevant to clinical care—such as anatomy, hormones, organs, chromosomes—as opposed to legal sex, sex assigned at birth, or gender identity. The HL7 Fast Healthcare Interoperability Resources standard includes an extension usable in patient portal or laboratory resources.[9] It supports the four-value schema: male, female, specified, and unknown. Health care providers are encouraged to adopt practices that respect and affirm patients' identities. The addition of SOGI fields over the last ten years have already established a basis of improving health care for the gender-expansive patient population.[10] This includes updating EHRs to distinguish between legal and chosen names, ensuring that staff are trained to use patients' chosen names and pronouns, and creating an inclusive environment that acknowledges and supports transgender patients.

EHR systems have been required to be capable of collecting SOGI data since a ruling by the Center of Medicare and Medicaid Services (CMS) in 2015[11], but reliability of these infrastructures have remained questionable by gender-diverse communities. Studies have shown that over 60 percent of adult EHRs are missing SOGI information[12], impeding the ability to identify and address health disparities within LGBTQ+ populations. Most EHRs now support distinct fields for legal sex, sex assigned at birth, gender identity, organ inventories (e.g., presence/absence of uterus, prostate, etc.), and context-specific sex fields that inform lab reference ranges, clinical decision support, and alerts.[13] This ensures correct testing and screening, and supports health equity and interoperability. Organ inventories are proven tools to ensure equitable, anatomy-based care. They are increasingly supported by leading EHR vendors and adopted by institutions like Epic[14], Geisinger[15], Allscripts[16], Department of Veterans Affairs[17], and Fenway Health.[17] Recommendations from the LGBTQ Primary Care Toolkit endorse voluntary SOGI and organ inventory disclosure through patient portals or clinic tablets[18], with clear messaging that patients may update or decline to provide this information—supporting autonomy and mental comfort. Successful integration depends on standardizing data, aligning workflows, providing training, and addressing anatomical complexity. Continued expansion is essential to close care gaps for transgender, gender-diverse, and all individuals with diverse anatomical realities.[19] While further EHR modifications[20] and staff training[21] to promote collection of more inclusive data have been a continued suggestion amongst those in the medical community, the quantifiable impact of these changes has yet to be determined.

DISCUSSION

Referring to a transgender individual's "chosen name" acknowledges their self-identified name as their actual name, not merely a preference. The term "preferred name" can imply that the name is optional or less legitimate, which may undermine the individual's identity. Queering Medicine, a grassroots advocacy organization for improving health outcomes, notes that the term "preferred name" is considered offensive by many in the transgender and nonbinary communities, as it suggests that others have the discretion to use or ignore it.[22] Additionally, using a transgender person's chosen name has been linked to significant reductions in mental health risks. A study

published in the *Journal of Adolescent Health* found that transgender youth who could use their chosen name in multiple contexts experienced 71 percent fewer symptoms of severe depression, 34 percent less instances of reported suicidal ideation, and 65 percent reduction in suicide attempts.[23] Ensuring the correct terminology is being used in the clinician's office is the first step increasing the patient's comfort, ensuring mutual trust, and improving health outcomes.

Data Interoperability

A lack of documenting gender (and related data like SFCU or organ inventory) can lead to clinical errors, poor patient experiences, and long-term harm. Systems and clinicians who thoughtfully record and use this information provide better, safer, and more affirming care.[24–26] A qualitative study of transgender individuals in Chicago found that structured gender identity fields (e.g., two-step questions) improved perceived provider competence, but also highlighted serious risks around privacy violations, misinterpretation, and compromised safety when disclosures were mishandled.[5] As part of another qualitative study, transgender patients who were asked to discuss their experiences reviewing their EHRs reported experiencing harm via various aspects of EHR documentation, including frequent use of incorrect names, pronouns, or gender; stigmatizing or blaming language in clinical notes; and limited system capabilities that hinder quality, equitable care.[27] According to a US Transgender Survey conducted by the National Center for Transgender Equality, 33 percent of transgender respondents reported a negative experience with a health care provider in the past year.[28] Using the 2015 U.S. Transgender Survey, a study that explored avoidance of health care due to anticipated discrimination among transgender adults found that almost one-quarter of participants (22.8 percent) avoided health care due to anticipated discrimination, deepening gaps in trust and care. Although legislative and regulatory efforts surrounding transgender care are rapidly evolving, several of these entities have, in the past, recommended structured collection of gender identity, sex assigned at birth, and related EHR data fields to protect privacy and support clinical decision-making. For example, a 2011 Institute of Medicine (now the National Academy of Medicine) report titled, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding", recommended that SOGI data be collected in EHRs with consideration for privacy concerns.[29] In 2023, the Department of Health and Human Services (HHS) published its SOGI Data Action Plan to improve data collection for the LGBTQ+ community and in turn, support more equitable representation and care.[30] Further, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) mandated in 2015 that certified EHR systems support the recording and display of gender identity, sex, "name to use", and pronouns, requiring full support for these fields by January 2026.[31]

EHRs not adequately accommodating both legal and chosen names not only creates significant challenges for transgender and gender diverse patients, but for the physicians and practices caring for them as well. Current systems often fail to record patients' names and pronouns appropriately, conflate sex and gender, and treat sex and gender as binary concepts. Many EHRs lack distinct fields for capturing both legal and chosen names, leading to chosen names being reverted to legal names previously stored in the system, repeated misnaming, and confusion during care—even when patients have clearly communicated their chosen name.[32] For example, many EHRs have historically used a single field that mixes administrative sex, clinical sex, gender identity, and pronouns under one category like "sex" or "gender".[33] Even when systems do provide multiple fields for this information, issues arise due to the need for different names in different settings such

as in the case of radiology information systems being linked to other medical records like Medicare. [32] A 2020 study at Rush University found that 76 percent of inpatient records lacked gender identity data, and a 2023 study at an academic medical center in New York found six discrepancies in transgender patients' documented gender identities[34]. Even when features (e.g., multi-part fields and dropdowns for pronouns) exist, they're not uniformly activated or used across vendor installations, meaning many users never see or use them. Additionally, sensitivity for identifying transgender individuals using EHR gender fields was remarkably low for data quality standards. These inconsistencies can result in administrative complications, as insurance billing and certain services (e.g., lab, x-ray, or procedures) all are governed by safety practices, the Health Insurance Portability and Accountability Act (HIPAA), and the Red Flag Rule, thus requiring verification of legal identity.[35] Furthermore, inconsistent documentation across systems can inadvertently expose a patient's transgender identity to providers, family, or friends, particularly in emergent situations, increasing the risk of discrimination and undermining trust in the health care system.[36]

To capture more accurate details, many EHRs enable free-text responses in the EHR SOGI field for patients to indicate their gender identity and pronouns in cases where an applicable option wasn't available. In a study that assessed how well SOGI fields, International Statistical Classification of Diseases and Related Health Problems, 10th Revision codes, and medication records identified gender-expansive patients, researchers reviewed free text responses from participants who selected "Other" in the SOGI field and responses included, "agender", "gender fluid", "gender nonconforming", "gender queer", indications of pronouns other than "he/him" or "she/hers", and "transfeminine" or "transmasculine".[10] However, free-text fields in EHRs have been reported to contribute to data overflow.[37] Information in these fields can become unmanageable for providers and potentially be overlooked. Managing this information also adds to physicians' time in the EHR, contributing to increased burnout. To address this burden, along with noisy SOGI data and incomplete and inconsistent gender identity documentation, researchers developed and validated a deep-learning natural language processing pipeline to accurately predict patient gender identity. Using a list of 109 expert-curated and literature-reported gender-related keywords, their model screened both structured data and free-text notes from over 3,000 patients in a large Boston health system to identify transgender and gender-diverse individuals. Compared with rule-based methods, the deep-learning model achieved substantially higher-accuracy, sensitivity, and precision.[38] However, a key limitation of such models is their reliance on existing EHR data, which may reflect provider biases and system constraints in capturing gender identity. As a result, these models risk reinforcing biases caused by inconsistent or inaccurate documentation, misgendering, and limited data fields. The Boston study experienced this challenge: in some cases, the model misclassified patients as transgender/gender-diverse based solely on procedures like a hysterectomy or vaginectomy, due to insufficient training data. Similarly, errors occurred when patients used they/them pronouns, reflecting an overgeneralization caused by limited training exposure to gender-diverse language.[38]

Without structured and manageable fields for sex assigned at birth, gender identity, SFCU, and organ inventory, clinical decision supports—a health IT tool that provides clinicians with knowledge and person-specific information to enhance care (e.g., computerized alerts, clinical guidelines, reminders, documentation templates, and condition-specific order sets)[39]—may miss important health risks such as cancer screenings, titrated lab interpretation, or medication needs.

Adopting and properly leveraging HL7 Gender Harmony and vendor toolkits is crucial, but must be paired with staff training, governance, and careful configuration to prevent implementation gaps.

Addressing Privacy Concerns

The collection of SOGI data in the United States is crucial for addressing health inequities and ensuring high quality care for LGBTQ+ populations. The terminology used in EHRs to refer to a patient's name—specifically, the distinction between "chosen name" and "preferred name"—has significant implications for privacy, security, and the well-being of gender-diverse individuals.

While HIPAA provides a framework for protecting patient information, it has limitations concerning SOGI data. For instance, certain legal interpretations have allowed for the disclosure of SOGI information without explicit patient consent, especially when such data are collected as part of demographic information rather than clinical record.[40] This was the case in Vanderbilt University Medical Center's (VUMC's) 2023 disclosure of the full medical records of transgender and gender-diverse patients to the Tennessee Attorney General amid an anti-LGBTQ+ political climate. The probe was prompted by claims that VUMC had improperly billed Medicaid for gender-affirming care. This disclosure was made without patient consent and sparked significant backlash, with critics arguing that it jeopardized the safety, privacy, and trust of transgender patients.[40,41]

The case also exposed broader vulnerabilities in federal privacy protections for this patient population. Under the HIPAA Privacy Rule, covered entities may disclose protected health information (PHI) without patient authorization if required by another law (provided such disclosure complies with the requirements of that law). In such cases, health care providers are not liable for these disclosures and often cannot prevent them. This loophole was a key factor in the VUMC case, raising concerns about the adequacy of federal safeguards for this kind of sensitive health data.[41] Compounding the issue, in early 2025, HHS rescinded its 2022 guidance that had previously offered protections for gender-affirming care and patient privacy[42], leaving transgender and gender-diverse patients and their providers with less clarity and even fewer protections to rely on.

Under HIPAA, a patient's name is considered PHI. This designation requires health care providers to implement safeguards to protect the confidentiality and integrity of patient names. However, HIPAA does not specifically address the nuances of chosen names for transgender individuals, potentially leaving gaps in protection when legal and chosen names differ.

The absence of comprehensive federal privacy legislation results in a patchwork of state laws, leading to inconsistent protections for SOGI data. In some states, there are no explicit safeguards against discrimination based on sexual orientation or gender identity, increasing the risk of data misuse. For example, in states without protective laws, individuals may face discrimination in housing, employment, or education if their SOGI information is disclosed.[43] Smaller practices are at higher risk of being unable to protect this data against federal threats, such as digital surveillance and geofencing of reproductive or gender-affirming care sites. Collecting gender and sexual orientation and gender identity data requires strong appropriate technical safeguards and privacy protocols to prevent trauma for LGBTQ+ patients, especially those with past misgendering or being outed in care settings.[44] Fenway Health and the VA implement EHR fields for gender

identity, anatomical inventories, and affirmation history, coupled with staff training, clearly explained data use, and privacy protections. These measures help prevent “re-traumatization” and enhance mental well-being.[15] Respect and transparency around data handling reduce the risk of re-traumatization and support positive patient outcomes. Oregon’s Equity & Inclusion Division highlights that collecting SOGI data demonstrates care and safety for LGBTQ+ individuals.[45] Paired with staff training and community-led input, it helps build trust, especially important in mental health screenings and identity disclosure contexts.

Even when minors can consent to sensitive care (e.g. sexual/mental health), EHR portals often default to giving guardians full access, risking unwanted disclosure of SOGI data.[46] A 2023 JAMA Pediatrics survey showed that approximately 50 percent of young adults avoid portal use and omit sensitive information for fear parents might see it, citing threats to their physical well-being if revealed to be transgender.[47] While collecting minors' SOGI data supports personalized care, privacy protections are often insufficient, leading to coerced disclosures, harmful breaches, and emotional risk. The Privacy Rule allows parents to access their minor children’s medical records as their personal representative when access isn’t inconsistent with state or other law. Exceptions to this are when parental consent is required by law; when the minor is directed by the court to obtain care; and when—and to the extent that—the parent agrees that the minor and provider may have a confidential relationship.[48] Additionally, even when state law permits confidential care, legislation like the 21st Century Cures Act still pose challenges. For example, the Cures Act’s open notes policy can unintentionally expose minors’ sensitive information to parents.[49] While the Cures Act builds on HIPAA to improve access to electronic health information, it doesn’t override HIPAA’s core privacy protections which allows disclosure of PHI for billing without consent.[50] Though data is limited, AMA physicians report such disclosures are common due to the lack of alternative workflows. Protecting minor privacy must extend to payers’ billing systems, not just providers and EHR vendors.[51] More robust technical, legal, and workflow standards must be researched to aid data collection and improve current systems.

Historical and ongoing discrimination against LGBTQ+ individuals fosters a climate of mistrust, making individuals hesitant to share SOGI information. Concerns about confidentiality breaches and potential repercussions can lead to underreporting or refusal to disclose such data, hindering efforts to gather accurate information for public health and policy-making purposes. Using "preferred name" instead of "chosen name" can inadvertently suggest that the name is optional or less legitimate, potentially leading to misidentification and privacy breaches. For transgender patients, being addressed by their legal name rather than their chosen name can result in unintended disclosure of their gender identity, especially in environments where they may not have disclosed this information. This misidentification can lead to emotional distress and a reluctance to seek necessary medical care–broadening the health disparity gap.

Unstable Political Landscape

The current political landscape in the United States has introduced a series of legislative and executive actions that have significant adverse effects on the rights and well-being of gender-diverse individuals and the physicians that care for them.

As of early 2025, 27 states have enacted bans on gender-affirming care for minors, with 26 of these 27 states prohibiting hormone therapy and surgeries for minors, and one state (Arizona) prohibiting

only surgical care.[52] Such bans are typically enforced by criminal, civil, and professional penalties for providers who furnish gender-affirming care services, as well as sometimes penalties for parents of children who support their children's access to this care.[53] Notably, these restrictions do not apply to services provided for purposes other than gender affirmation, such as treatments for disorders of sexual development and precocious puberty. As of July 2025, 40.1 percent (120,400) of trans youth aged 13-17 are living in the 27 states that have passed bans on gender-affirming care.[54] Despite the protections afforded in states with "shield laws" designed to protect access to abortion and gender-affirming care, these laws are currently being challenged.[55–57] Given the strong correlation between transgender individuals and mental health, state-level anti-transgender policies exacerbate these issues. Public health experts warn that such policies not only harm individual well-being but also strain health care systems and exacerbate inequities.[58] The denial of gender-affirming care and the erosion of legal protections necessitate urgent attention and intervention.

On January 20, 2025, Executive Order 14168 was signed, mandating federal agencies to recognize only a binary definition of sex based on biological attributes assigned at birth. This order rescinded federal recognition of transgender identities, ceased funding for gender-affirming care, and prohibited the use of gender self-identification on federal documents.[59] Additionally, it called for a reevaluation of Title VII protections concerning gender identity. Subsequent directives led to the removal of federal data sets and resources related to sexual orientation and gender identity from government websites, hindering research and public health initiatives aimed at addressing the needs of LGBTQ+ populations. These events reflect a broader trend of institutional censorship affecting educational resources related to gender diversity.

The politicization of transgender rights has broad societal implications, including intensified stigma and marginalization, and the undermining of the rights, health care access, and well-being of these communities. These challenges underscore the urgent need for informed advocacy and policy reform, especially efforts that address how inadequate privacy protections leave LGBTQ+ individuals vulnerable. Navigating the shifting political landscape requires careful attention to evolving attitudes—as well as emerging knowledge and best practices—from LGBTQ+ communities and their providers.

CONCLUSION

Aligning medical documentation with the needs of transgender and gender-diverse patients is a critical step toward addressing long-standing health inequities. This report highlights the importance of supporting the voluntary, culturally sensitive inclusion of gender identity, "chosen names", and organ inventories to promote safer, more accurate, and affirming care. Many EHR vendors have already made strides in supporting this type of data collection, but more research is likely needed on specific efforts and impact of use across the health care system.

Affirming practices—such as using "chosen names" and linking screenings to anatomy rather than gender identity—are supported by strong clinical and mental health evidence, but ongoing challenges highlight the need for robust privacy protections. While some federal protections have been rolled back or face legal threats, laws like HIPAA and state confidentiality statutes still mandate safeguards, though they may be limited in their protection of transgender patients. Smaller practices may also lack the resources to implement optimal data protections. Informed consent and the option to opt out without compromising care are essential to maintaining patient trust.

In addition, there is a lack of consensus and consistent use of key terms such as clinical sex, raising concerns about the longevity of this resolution if adopted. Improving the usability of EHRs for transgender and gender diverse patients requires ongoing collaboration among the LGBTQ+ community, physicians, health systems and practices, and EHR vendors. Medical documentation that appropriately supports this patient population while upholding the highest privacy standards to protect these patients and the physicians that care for them, would be a vital step toward a more equitable and responsive health care delivery system.

AMA POLICY

The AMA has adopted several policies to support gender-diverse individuals in health care, foster care, and legal protections.

The 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 (Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation")

The AMA will also advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data (Policy H-440.817, "Protecting the Integrity of Public Health Data Collection").

Additionally—given the medical spectrum of gender identity and sex—the AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth (Policy D-295.312, "Medical Spectrum of Gender").

The AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors (Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity").

Further, the AMA continues to (1) support the dignity of the individual, human rights and the sanctity of human life; (2) reaffirm its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; and recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Policy H-65.965, "Support of Human Rights and Freedom (H-65.965)

The AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Policy H-65.976, "Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations").

Additionally, AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity (Policy H-65.983, "Nondiscrimination Policy") Regarding LGBTQ+ older adults, AMA will disseminate educational content to increase awareness and understanding of LGBTQ++ health aging issues among the general public, health care professionals, and policy makers; promote cultural competency training for clinicians in caring for LGBTQ++ older adults; promote policies and practices for implementation within all health care settings that are inclusive and affirming for LGBTQ++ older adults; and advocate for increased funding and resources for research into health issues of LGBTQ++ older adults (Policy D-65.979, "LGBTQ+ Older Adults")

Moreover, our AMA:

1. Believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all

physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people (Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations").

Further, AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth (Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations").

AMA will also develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership (Policy D-315.974, "Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms").

Regarding research and the LGBTQ+ communities, AMA will work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations (Policy D-460.966, "Endorsing LGBTQ+ Research IRB Training").

In addition, AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently

collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Policy H-65.957, "Preventing Anti-Transgender Violence").

Further, AMA:

1. Recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.
4. Encourages (a) efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk; as well as (b) continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
5. Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults; and research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
6. Will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
7. Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health.
8. Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults

9. Will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide Prevention").

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 004-I-24 and the remainder of the report be filed:

1. Our AMA reaffirm Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation." (Reaffirm HOD Policy)

2. Our AMA support the use of the term "chosen name" over "preferred name," recognizing its importance to transgender and gender-diverse patients. (New HOD Policy)

3. Our AMA acknowledge the evolving nature of language and engage appropriate stakeholders to ensure the continued relevance and accuracy of terminology used across AMA resources and advocacy. (New HOD Policy)

4. Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant stakeholders (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong privacy protections, and report back on this progress by I-26. (New HOD Policy)

Fiscal Note: Moderate

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-25

Subject: Supporting Diversity in Research

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2024 Interim Meeting, the House of Delegates (HOD) referred Resolution 007-I-24, "Supporting Diversity in Research," introduced by the Minority Affairs Section, which offered four resolves aimed at improving diversity in research:

> RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes (New HOD Policy); and be it further
>
> RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further
>
> RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" (Directive to Take Action); and be it further
>
> RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

In response to Resolution 007, this report provides background, discussion, and recommendations.

BACKGROUND

Ideally, the makeup of research participants (or human subjects) would closely resemble the demographic diversity of the general population or the prevalence of a specific disease.[1] Despite federal regulations aimed at promoting participant diversity in research, it is widely acknowledged that there is a need for greater diversity and inclusion in clinical trials and health research.[2,3] Improving diversity in clinical research would help strengthen the generalizability, external validity, and quality of research results.[4,5] Improving representation in clinical research would also reduce health disparities, potentially saving the U.S. billions of dollars, improve trust in science and medicine, and help promote public health and health equity.[4,6] Because improving research participant diversity promotes trust, fairness, justice, and health equity, achieving greater representation in clinical research is not only a scientific imperative but an ethical one as well.[4,7]

DISCUSSION

Enrolling diverse research participant populations is crucial to ensure accurate and equitable outcomes, as disease prevalence and responses to treatments can vary significantly across different groups.[8] Underrepresentation of certain groups in research can lead to biased findings and ineffective interventions for those populations. Despite evidence of recent increases in participation by women and elderly individuals in clinical trials, research participants remain mostly white and male.[6] Groups that are frequently underrepresented in clinical research include, but are not limited to, non-white women, pregnant and lactating individuals, gender minorities, sexual minorities, racial and ethnic minorities, individuals with disabilities, individuals with mental illness, older adults, children, and individuals with limited English proficiency (LEP).[3,6,9] Because some subgroups of patients might respond differently to interventions due to genetic, social, and cultural factors, ensuring diversity within research study cohorts is crucial to ensure that research is generalizable, that the risks and benefits of research are fairly distributed, and that research does not perpetuate existing health inequities.[8] By including underrepresented and excluded groups, research may lead to more effective therapies that can help reduce health disparities.[4] Inclusive enrolment practices can also lead to increases in participation and greater public trust in science and medicine.[7]

Federal Regulations and Research Participant Diversity

In the U.S., federal regulations require diversity in research participation, particularly in federally funded studies, to ensure that research findings are generalizable and equitable. The National Institutes of Health (NIH) Revitalization Act of 1993 mandates that NIH-funded clinical research include women and minorities as participants.[10] In 2019, the NIH instituted the Inclusion Across the Lifespan policy, mandating that NIH-funded research include individuals of all ages, including children and older adults, unless there exists scientifically or ethically justifiable reasons for exclusion.[11] The Common Rule (45 CFR 46), which outlines federal protections for human research participants, emphasizes equitable selection of participants; it also states that in obtaining informed consent, all information given to the research participant (or their legally authorized representative) must be in language understandable to them.[12] The U.S. Department of Health and Human Services' Office for Human Research Protections, in their guidance "Informed Consent of Subjects Who Do Not Speak English" published in 1995 and last reviewed in 2016, similarly states that when obtaining informed consent, information should be presented in language understandable to the participant.[13] However, despite these regulations, underrepresentation and exclusion of certain groups in research persists.

One challenge to improving representation in clinical research has been that data on population demographics across clinical trials has not been consistently reported. Demographic data of participants enrolled in clinical trials in the U.S. is most readily collected by ClinicalTrials.gov (a registry maintained by the National Library of Medicine at the NIH), but limitations on how often and how comprehensively data are collected and made available have made longitudinal institute-level data difficult to examine, and not all trials report their demographic characteristics.[6] It is therefore crucial that policies be developed to ensure that more complete incidence data across demographic groups and subgroups are captured and disseminated for more conditions in order to improve clinical research diversity.[14]

In addition, it has been argued that federal regulations and guidance are insufficient and overly vague on issues related to language diversity for informed consent and exclusion criteria for clinical trials, and that there exists considerable variation in IRB policies.[3,15] Recent executive orders, which have revoked previous orders directing federal agencies to address disparities,

including in research funding and participation, have further complicated attempts at addressing underrepresentation and exclusion of certain groups in clinical research.[16,17]

Improving Enrollment Diversity

Strategies to improve the representation of participants in clinical research requires the engagement of multiple stakeholders and must be embedded at every stage of the research process, from ideation, to study design, implementation, and approval and dissemination.[6,9] However, Collister et al. acknowledge, "Diversity in recruitment requires additional resources, time, and skills from trial teams, and this requirement for diversity needs to be balanced with the feasibility and generalizability of the trial."[5] They add that new systems-level approaches to increase participant diversity need to be developed for both industry and investigators.[5]

To facilitate the successful inclusion of underrepresented and excluded groups in research, several strategies have been developed. For example, in the National Academies report "Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups," the authors note, "From goal setting to community partnering strategies, intentionality and planning are critical themes for overcoming the systemic barriers previously outlined […]. While planning and engagement with diverse communities is resource, time, and labor intensive, it is critical to advancing inclusion."[6] This highlights the fact that equitable representation in clinical research must be a goal from the onset. They add, "Setting a priori recruitment goals for the inclusion of underrepresented groups is essential to planning and can help research teams measure progress and develop more effective engagement strategies".[6]

Other strategies outlined include building and maintaining trust with research participants and their communities at large; anticipating and removing barriers to participation; identifying and reaching out to relevant community stakeholders to help develop more equitable study designs and drive recruitment and retention of diverse research participants; and educating researchers on strategies to increase the enrollment of diverse participants, including the use of broad eligibility criteria and avoiding sex-specific exclusion criteria.[6]

The FDA, in collaboration with the Clinical Trials Transformation Initiative, held a two-day virtual public workshop in 2024 focused on ways to increase the enrollment of historically underrepresented populations in clinical studies and promote greater representation in research. Panelists discussed barriers to clinical study diversity and "how strategies to improve diversity should consider the languages and varying levels of health and digital literacy, broadband access for digital tools, and accessibility among potential participants to enable inclusive and equitable participation."[9] Other strategies discussed included "targeted patient engagement plans, enhanced site selection and inclusive patient educational materials using decentralized trial tools, digital technologies, choosing sites that are located in diverse areas, protocol optimization with inclusive study design elements, and using patient concierges to help with scheduling and reimbursement for travel and transportation."[9]

With respect to individuals with limited English proficiency, Muthukmar et al write, "A meaningful percentage of U. S. interventional clinical trials for adults exclude individuals who cannot read, speak, and/or understand English, or are not native English speakers. To advance more inclusive and generalizable research, funders, sponsors, institutions, investigators, institutional review boards, and others should prioritize translating study materials and eliminate language requirements unless justified either scientifically or ethically."[18] In their analysis, they found that 18.98 percent of clinical trials required the ability to read, speak, and/or understand English, while only 2.71 percent specifically required accommodations for translation. They add that funders and

sponsors should include translation costs as a matter of course, that institutions with access to translation or interpreter services for clinical purposes could extend these services to researchers, and that IRBs should develop standardized guidelines for the implementation of translators, which currently do not exist.[18]

A common refrain when it comes to increasing participant diversity in research is the importance of building trust with local communities.[2,4,6,9] *JAMA* Editor-in-Chief Kirsten Bibbins-Domingo explains, "Building trust with local communities requires a sustained commitment and presence, with financial investment in research infrastructure and systems and technologies to reduce barriers to participation."[2] This requires adopting the collaborative mindset and long-term commitments central to community-based participatory research, which aims to bring equity into the center of research projects by collaborating with community members and other stakeholders throughout the research process to address community needs. Bibbins-Domingo notes, "This begins with community-centered engagement and prioritization across the research life cycle, from the substance and design of questions being asked, to culturally cognizant recruitment and retention of study participants, to analysis and reporting of results, and to monitoring and reporting across the research ecosystem to ensure that the goals of inclusion are met."[2] Of course, there is wide acknowledgement that strategies to increase participant diversity will require additional resources but that committing to doing so will help advance more inclusive and generalizable research.

In addition to strategies aimed at fostering trust and improving enrollment diversity, clinical researchers should also reconsider eligibility criteria for participation in research. A study by Plosky et al. found that 85 percent of protocols allowed broad investigator discretion in determining eligibility and often utilized phrasing so non-specific or expansive as to render entire groups ineligible.[3] They suggest that eligibility criteria be as inclusive as possible, that written justification be provided so that oversight bodies such as IRBs could review whether exclusion is justified, and that accommodations be considered, such as virtual visits, additional time for the informed consent process, communications assistance, American Sign Language interpreters, or transportation to study appointments.[3]

For LEP individuals, the provision of interpreters or translators could greatly reduce the underrepresentation of this group in clinical research. An interpreter is generally a person trained in the language of health care who conducts live interpretations between two people, while a translator is generally someone who translates text-based documents between the source language and the target language.[19] In thinking through the language support needed for a clinical trial, Willis et al. state, "it is important to distinguish trial contexts where language is required solely as part of the informed consent process (an ethical imperative for all research participants) and trial contexts where language is part of the intervention."[8] Generative AI models have recently been proposed as one means to meet the needs of LEP individuals and foster greater inclusion in clinical research. However, these technologies must be considered alongside issues of accuracy, safety, privacy, and other risks involved. For instance, due to differences in languages available for AI model training, translation performance in the US is significantly better for Spanish than for other languages with less diffusion, creating a higher risk for clinically significant errors for these linguistic populations.[20,21]

While digital health technologies, such as generative AI translators, may help support the inclusion of underrepresented and excluded populations, they should not be considered solutions on their own. Barriers such as a lack of broadband, digital literacy, and the potential for embedded biases should be carefully considered. It is also crucial not to dismiss the importance of building human connection with participants and communities, which is vital to building and sustaining trust.[9] To support enrollment diversity, all study protocols should include considerations for diverse linguistic

groups, including LEP, deaf, and hard of hearing individuals and should provide clear protections for these groups during the informed consent process. As Alhalel et al. state, "Fulfilling the ethical demands for inclusive clinical trials also requires research funders to prioritize language access by including expenses for language assistance resources in all clinical trial budgets."[22]

RELEVANT AMA POLICY

AMA policies that support participant diversity in research include H-525.988, "Sex and Gender Differences in Medical Research," which affirms support for including "people of all sexes and gender identities and expressions in studies that involve the health of society at large".[23] H-460.881, "Increasing Diversity in Stem Cell Biobanks and Disease Models," encourages "participation by underrepresented populations" and the collection of "racially and ethnically diverse sample" to "better represent the population."[24]

Though not specific to research, H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," states that "patients should have access to documentation and communications in their preferred language" and that "physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires".[25] And H-180.944, "Plan for Continued Progress Toward Health Equity," defines health equity as a goal of our AMA.[26]

The AMA *Code of Medical Ethics* also contains several relevant opinions. Opinion 7.1.1, "Physician Involvement in Research," states that research participants "must be able to make informed decisions about whether to participate or continue in a given protocol."[27] Opinion 7.1.2, "Informed Consent in Research," states that physicians must ensure that research participants have "given voluntary, informed consent before enrolling".[28] Opinion 8.5, "Disparities in Health Care," states that physicians should "Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system" and support "the development of quality measures and resources to help reduce disparities."[29] And Opinion 11.2.7, "Responsibilities to Promote Equitable Care," states that physicians should "Identify institutional policies and practices that perpetuate or create barriers to equitable care" and "Participate in designing and supporting well-considered strategies for change to ensure equitable care for all."[30]

Viewed collectively, these policies reveal a commitment to supporting health equity, patient-centered care, and quality research, and provide a foundation for further policy development aimed at reducing the underrepresentation and exclusion of certain groups from clinical research.

CONCLUSION

While Resolution 007-I-24, "Supporting Diversity in Research," focused specifically on the need to increase representation of LEP individuals and deaf and hard of hearing people in clinical research, this report has examined the importance of supporting diversity in research for all underrepresented and excluded populations. Lack of participant diversity in research is an urgent problem that needs to be addressed. It is critical, for example, that the clinical researchers examine how various populations are defined and how these definitions impact who is included or excluded.[6] It is important to note, however, that barriers and solutions will vary by topic or field of study, the population, intervention, and the trial setting, such that local approaches will likely be more successful than one-size-fits-all practices.[5] For example, eligibility criteria should only be as strict as is medically and ethically necessary, and categorical exclusions should be avoided in favor of

criteria that can be objectively assessed on an individual basis.[3] While strategies for promoting inclusion should not be overburdensome to the point of limiting the feasibility of carrying out research, improving diversity in clinical research is an ethical and scientific imperative that will lead to improved generalizability and health equity.[4,8]

Achieving greater representation in research will require a multifaced approach. Community engagement, decentralization of research sites, and use of digital tools can all enhance the accessibility of clinical research, and improving representation among investigators and clinical research staff may translate to improved recruitment and retention of underrepresented groups.[4] Gross et al. state, "It is imperative that industry sponsors and academic investigators embrace diversity in research and development to address the variability of individual patients treated"—highlighting the importance of centering representation at every stage of the research program.[14] True reform will require greater outreach to communities, targeted recruitment strategies, improved IRB and regulatory oversight, and stronger federal regulations and guidelines. As Hwang and Brawley acknowledge, "new diversity provisions [by the House of Representatives] do not fully resolve the underlying causes of a lack of representativeness in clinical trials, which include restrictive eligibility criteria, costs associated with participation, limited enrollment outreach in marginalized racial and ethnic communities and in safety-net facilities, implicit English-language requirements, and systemic inequities in access to care."[31] Addressing these systemic barriers will require a concerted effort and commitment by all stakeholders involved in clinical research.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 007-I-24 and the remainder of this report be filed:

1. That our American Medical Association support the use of language interpreters and translators, at a cost not to be funded by the physician, in clinical trials and health research participation to promote equitable data collection and outcomes. (New HOD Policy)

2. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish standardized guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people. (New HOD Policy)

3. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for improving the diversity of research participants, including (1) that eligibility criteria be as inclusive as possible, (2) that written justification for exclusion be provided for review, and (3) that additional accommodations for potential enrollees be considered. (New HOD Policy)

4. That our AMA support greater inclusion in clinical trials and health research of all peoples and groups that are underrepresented or excluded from such research to promote greater study generalization, health equity, and justice. (New HOD Policy)

5. That our AMA support community-centered engagement before, during, and after clinical trials and health research to foster and sustain public trust in medicine and science. (New HOD Policy)

6. That our AMA encourage that all study protocols involving human research participants include appropriate funding to support the inclusion of underrepresented and excluded populations. (New HOD Policy)

Fiscal Note: Minimal – less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-I-25

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Resolution 017, "Addressing the Historical Injustices of Anatomical Specimen Use," was adopted at the 2024 Annual Meeting by the House of Delegates (HOD) and codified as H-140.820.[1] This report responds to a directive in section 6 of H-140.820 which asks our AMA to:

> Study and develop recommendations regarding regulations for ethical body donations including, but not limited to, guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue.

BACKGROUND

In the wake of the recent Harvard anatomical donation scandal, in which the school's former morgue manager was allegedly stealing and selling human body parts, concerns surrounding cadaveric donation policies have come under renewed scrutiny.[2,3] The history in the U.S. regarding procurement of bodies for dissection and educational purposes has included grave robbing,[4] the looting of native burial grounds,[5] and the use of bodies without consent.[6] Presently, several of America's most prestigious museums, including those at Harvard University, the University of California-Berkeley, and the Field Museum in Chicago, still claim stolen human remains, igniting fierce debate, criticism, and calls for their return.[6] Additionally, several U.S. states—including Ohio, Oregon, and Texas—allow medical education on "bodies without informed consent" that remain unclaimed and 12.4 percent of U.S. medical schools self-report using unclaimed bodies.[7] The use of bodies as anatomical specimens without informed consent raises questions about the ethics of body donation and anatomical specimen procurement and use.

DISCUSSION

Despite the historic injustices surrounding how bodies have been procured, there has not been any standardized policy guiding the ethical donation of human bodies and anatomical specimens. Due to the recent scrutiny related to a lack of ethical body and anatomical specimen donation policies, the American Association for Anatomy (AAA) assembled a task force of experts to determine best practices and develop standards for body donation.[8] The task force developed foundational and aspirational recommendations which they published as "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy".

The task force report grounds their best practices and foundational recommendations on informed consent as the fundamental ethical tenet underlying body donation.[8] Importantly, the report calls for body donation policies to include a mandatory standard for informed consent as a matter of justice and to not use the bodies of unclaimed individuals, despite what individual state laws may

allow. Additionally, the task force identified core operational practices to be implemented with mechanisms for oversight that are pertinent for ensuring an ethical body donation policy. Core operational practices include the following:

1. *Outreach*: This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.

2. *Registration*: A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e. military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.

3. *Custody*: A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g. researchers, educators, clinicians).

4. *Tracking*: A tracking system should be put in place to ensure proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

5. *Use*: Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.

6. *Disposition*: Final disposition of the body should be made in accordance with the wishes of the donor and their families.

7. *Memorialization*: A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

To ensure that these core operational procedures are upheld, the task force calls for policy setting, dissemination, and training on the implementation of these guidelines. Additionally, the AAA conceives this guidance to be a "living document intended to be periodically modified and updated as the ethos and legislation of body donation evolve."[8] The AAA guidelines are intended to ensure transparency and accountability during every aspect of the body donation process from solicitation for use of bodies to the respectful disposition and memorial at the conclusion of use. The AAA guidelines were approved by the AAA's board of directors in 2024.

CONCLUSION

In response to the need for standardized policy guiding the ethical donation of human bodies and anatomical specimens the AAA recently published "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy". The AAA guidance is grounded in key ethical principles, including privacy, respect, justice, and

non-maleficence and is thoughtful, well-researched, and comprehensively addresses the issue by experts in the field.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. Our AMA supports the guidelines set forth by the American Association for Anatomy's 2024 best practices and recommended standards for human body donation programs. (New HOD Policy)

2. That section 6 of H-140.820 be rescinded as having been accomplished by this report

Fiscal Note: Minimal – less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-1-25

Subject: Bylaws Review Report

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

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Annual Meeting, the House of Delegates referred CCB Report 1-A-25, Bylaws Review Report, back to the Council. CCB Report 1 proposed bylaw amendments related to inconsistent, incomplete or inaccurate bylaw provisions, most notably those associated with the filling of vacancies. Online and in-person reference committee testimony was supportive of changes other than those that focused on the Board's role vis-à-vis that of the Medical Student Section (MSS) when appointing student members to American Medical Association (AMA) Councils and in filling a vacancy in the Medical Student Trustee position.

The MSS testified that it was not opposed to language requiring its governing council to submit two or more nominees for each Council position as the section's practice was to submit multiple nominees for each position. However, the testimony opposed new language paralleling existing language governing the filling of the Medical Student Trustee vacancy which explicitly stated the Board could request additional nominations. Lastly, the MSS supported deletion of that long-existing language codifying the Board's prerogative to request additional nominations from the MSS Governing Council before appointing a Medical Student Trustee to fill the vacancy.

The Council committed to better understanding why existing bylaw language related to a student trustee vacancy and its proposed changes to the student councilor appointment process was problematic. In doing so, it looked at the history of the medical student trustee position as well as the current and historical processes used by the MSS and the Board to appoint student members of the AMA Councils. It also looked at the Board's Standing Rules, which provide specificity regarding the Board's processes in making all appointments.

BACKGROUND

The Medical Student Trustee position came into existence as a result of BOT Report W-A-83 in which the Board proposed to create a "slotted" seat for a medical student on the Board. This recommendation followed years of inviting a medical student to attend Board meetings as a guest, with a later policy of formally inviting the guest medical student to contribute to the Board deliberations. BOT Report W-A-83 noted that "students traditionally were afforded a separate participation status due to their limited time in a student membership category" and thus the Board proposed a mechanism comparable to how student members of the AMA Councils were then selected -- whereby the MSS provided two or more nominations to the Board, who would then select and confirm one of the candidates. [Earlier processes for student members of councils entailed House election of nonvoting medical student members of some but not all AMA Councils from among medical student candidates presented by the Board of Trustees from among nominations submitted by the MSS; however, by 1983, the House was no longer involved in selecting the medical student councilors]. The House adopted the Board proposal that the medical

student trustee position be created as a nonvoting position similar to student council positions whereby the Board vets the MSS-submitted student nominees.

As the creation of a student trustee position required a change to the AMA Constitution as well as Bylaws, the House acted on the bylaws via CCB-A-I-83. The Bylaw language addressed the appointment of the student trustee from among nominations submitted by the MSS Governing Council as well as filling a student trustee vacancy from among two or more nominations similarly submitted by the MSS. In both cases, the House adopted bylaw language that enabled the Board to request additional nominations.

Nearly a decade later, the MSS submitted a resolution proposing that the MSS directly elect the student trustee. BOT L-I-91, Medical Student Trustee Selection Process, addressed the referred resolution but also provided a historical background on the student nomination process. While the 1983 Bylaws specified two or more nominations from the MSS governing council, in practice student applicants were solicited from among the MSS membership. The MSS Assembly then elected three nominees, the Governing Council forwarded those three names to the Board, and then the Board selected a student for appointment. For the first five years, the MSS ranked the nominees, with the Board consistently selecting the first ranked student. Beginning in 1990 the Board requested that candidates be unranked and in 1991 recommended that the MSS directly elect the nonvoting student trustee. BOT Report L-I-91 also noted that "Since the House of Delegates does not elect the student trustee, it is important for the Board to continue to play a role in selection of the student trustee as it does in the selection of student representatives to most AMA Councils." In separate action in 1991, the student trustee was also given voting privileges on policy-making matters, and the House adopted the requisite constitutional and bylaws changes in 1992.

DISCUSSION

While CCB Report 1-A-25 came about as part of the Council's ongoing responsibility to ensure clear and consistent Bylaws, the Council learned that the Board itself had been looking at the current student appointment process with an eye toward making improvements to increase the candidate pool. In 2025, a Board-appointed subcommittee articulated its concern about how the MSS Governing Council often selected students who have already served in an MSS leadership role for additional leadership positions on AMA councils and committees. The Board then was compelled to vote for a specific candidate as most but not all ranked nominees were recommended for multiple positions due to the MSS application process that allowed students to rank their choice of three councils rather than apply for just one. In follow-up, the Board asked the MSS to implement changes such that student candidates would apply for a single position only to ensure that the Board would receive a greater variety of applicants. The goal was to have MSS provide at least two candidates per position with diverse candidates representing students in their early years of medical school, students from traditional four-year programs and students from programs of longer duration that often culminated in multiple degrees.

After the House referred CCB Report 1-A-25 back to the Council, the Council confirmed with the Board its support of the Council's recommendations to require two or more nominations for any student council positions. The Council also confirmed the Board's prerogative to request additional nominations for any appointed position should be referenced in the Bylaws with respect to student positions, as those student positions are the only positions referenced in the Bylaws where nominees come from a single source.

Throughout its discussions, the Council acknowledged that the student trustee and the student council members are managed differently than all other AMA leadership positions. Whereas the House elects every other trustee position, the MSS itself elects the medical student trustee with no House involvement. In electing the trustees for the other two Board seats that exist for special time-limited membership segments -- the Resident and Fellow Trustee and the Young Physician Trustee -- the House elects from among candidates that may be nominated by the Federation. In 2024, the House defeated a proposal that would have allowed the RFS to elect the Resident and Fellow Trustee in similar fashion to how the MSS elects the Medical Student Trustee. The Council also noted that while all three time-limited trustee positions were created to give voice to a specific time-limited membership segments, those trustees indeed represent all physicians and medical students.

In further reviewing the Board's Standing Rules, the Council examined the role of the Awards and Nominations Committee, the body that advises the Board on all awards and nominations. Awards and Nominations present a recommendation from the list of nominees for each vacancy, with the Board voting on the nominations. The Standing Rules state that when a single nominee remains after the nominations have been declared closed, the Board may accept or reject said nominee for appointment, and when rejecting a nominee, the Committee then is tasked with presenting additional nominees for the position. The Council concluded that since the Board confirms nominees for any vacancy that occurs with the Medical Student Trustee position, student positions on all councils and any ensuing vacancies, these positions are under the purview of the Awards and Nominations Committees, which manages these as appointed positions. The Council, in resubmitting its bylaw language to acknowledge the Board's prerogative of being able to request additional nominees, emphasizes this is not unique to MSS positions as it applies to any Board-appointed positions. However, while not unique, the Council believes the language should be included in the Bylaws as the Board's role with these positions is indeed unique as contrasted with all other positions cited in the AMA Bylaws. The hope is that the Board's suggestions to the MSS about ways to modify its application process and to expand the applicant pool will allow for more diverse candidates and culminate in a new process that obviates the need to ever ask the MSS to submit additional nominations.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

3--Officers

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3.6 Vacancies.

3.6.1 Appointment. The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee ~~shall~~ may be filled by appointment by the Board of Trustees from a minimum of two ~~2 or more nominations~~ nominees submitted ~~provided~~ by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6--Councils

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6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, ~~2~~ two members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member ~~appointed~~ shall be a medical student member appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician member and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a 4four-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a ~~2~~two-year term.

6.6.5.3 Medical Student Member. If the medical student member of the Council ceases to complete the term for which appointed, the Board of Trustees may appoint a successor to fill the remainder of the unexpired term from a minimum of two nominees submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7 Council on Legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed by the Board of Trustees from a minimum of two nominees ~~nominations~~ submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7.3 Term.

6.7.3.1 Members of the Council on Legislation shall be appointed for terms of one year, beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

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6.7.5 Vacancies. Any vacancy, with the exception of a vacancy in the medical student position, occurring on the Council ~~shall~~ may be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

6.7.5.1 Medical Student Member. If the medical student member ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointments.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than ~~8~~eight years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting with the exception of a medical student who is appointed to fill a vacancy.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4four-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils cease~~s~~ to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a ~~2~~two-year term.

6.9.3.3 Medical Student Member. If the medical student member of these Councils ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician member of a Council who completes residency or fellowship within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. A medical student member of a Council who graduates from an educational program during their term shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-25

Subject: Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting

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

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Annual Meeting, the House of Delegates adopted CCB Report 3, Clarifying Bylaw Language, which recommended changes to the American Medical Association (AMA) Bylaws that streamlined AMA's membership categories to be: Active Members, Honorary Members, International Members and Affiliate Members. Previously, Active Membership included two distinct categories -- Active Constituent Members (those who paid their dues through their constituent association) and Active Direct Members (those who remitted their dues directly to the AMA). It was brought to the Council's attention that the definition of Active Member should more clearly reflect that the AMA Active Member category was open only to international medical graduates who worked or lived in the United States.

Also, at the 2025 Annual Meeting, several HOD members sought a bylaw interpretation from the Council on Ethical and Judicial Affairs (CEJA) with respect to Bylaw 5.3.9, and questioned whether the HOD had the authority to constitute an advisory committee, or whether that was a privilege of the Board. CEJA's interpretation opined that based on other bylaw language about the fiduciary role and authority of the Board in implementing HOD policy as well as historical precedence associated with other advisory committees that it was the Board's responsibility to not only appoint members to these committees (as detailed in Bylaw 5.3.9) but also to constitute them. The Council and CEJA agreed that the existing Bylaw language should be clarified.

The Council has proposed bylaw amendments to ensure clarity and accuracy.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

1--Membership

1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active Members, Affiliate Members, Honorary Members, and International Members.

1.1.1 Active Members.

1.1.1.1 Active Members. Active members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO)~~, or a recognized international equivalent~~;

b. Work or reside in the United States and possess a recognized international medical degree equivalent to the United States MD or DO; or

~~b~~. c. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.4 International Members.

Physicians who have graduated from medical schools located outside the United States and its territories and are ineligible to be Active Members and who can fulfill and document the following requirements:

a. Graduation from a medical school listed in the World Health Organization Directory.

b. Possession of a valid license in good standing in the country of graduation or practice location documented by one of the following:

(i) verification that the applicant is an international member of a national medical specialty society seated in the House of Delegates that has a procedure to verify the applicant's educational credentials;

(ii) certification from the national medical association in the country of practice attesting to the applicant's valid authorization to practice medicine without limitation; or

(iii) certification from the registry or licensing authority of the country of practice attesting to the applicant's valid license in good standing.

5—Board of Trustees

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5.3 Duties and Privileges. In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustees actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

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5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

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5.3.9 Establishment and Appointment of Committees. Establish ~~Appoint such~~ committees ~~as~~ necessary to carry out the purposes of the AMA and appoint committee membership.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

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5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-25

Subject: Credentialing of Temporary Delegates and Alternate Delegates

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

Referred to: Reference Committee on Ethics and Bylaws

Over the years, the Office of the House of Delegates Affairs, the Speakers and members of the House of Delegates (HOD) have been confused about several existing Bylaws that focus on the credentialing of delegates and alternate delegates, especially when a temporary replacement is needed when the original credentialed delegate or alternate is unable to attend a meeting in whole or in part. Specifically, the Speakers recently noted that they as well as delegations experienced difficulties at A-25 trying to follow existing Bylaws 2.10.4 and 2.10.4.1 and expressed strong support for a single designation to identify those delegates and alternate delegates who were taking the place of a previously credentialed delegate or alternate delegate for all or the remainder of the meeting.

The Council, whose members include the Speakers, looked at the Bylaws and agreed that the terms temporary delegate or temporary alternate delegate were better terms to characterize individuals who were taking the place of another individual who had been credentialed by their society at least 45-days in advance of a HOD meeting. For credentialing purposes, all individuals whose names and contact information were submitted by the 45-day deadline in advance of a meeting, even those delegates or alternate delegates who are filling vacancies for their societies, are not designated as a substitute delegate or alternate delegate and thus receive the privileges of their position.

The Council, however, in looking at these and other provisions that govern the credentialing of delegates found several outmoded and/or unnecessary provisions. Specifically, the term of a delegate or alternate delegate representing a federation entity, while currently referenced in AMA Bylaws, is established by the entity that the individual represents and not the AMA. Also, the language related to certification is outmoded when specifying how delegates and alternate delegates are credentialed. Language regarding some delegate and alternate delegate vacancies was similarly problematic. Additionally, earlier this year, the Speakers, the Council and the Resident and Fellow Section (RFS) noted a discrepancy with respect to the RFS sectional delegates and alternate delegates. Existing Bylaw 2.4.6 provided that a delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of the term, yet Bylaw 2.4.3 stated that delegates and alternate delegates shall be elected (not selected) by the RFS in accordance with procedures adopted by the Section.

Lastly, in keeping with the criteria by which AMA's Emergency Assistance Program funds are allocated, it is essential that the Bylaws are accurate when referencing the process by which duly credentialed members of the House are identified for each meeting as well as the process by which a vacancy is filled.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (highlighted in RED) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

2.0.1 Composition and Representation….

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

2.0.1.2 Rights and Privileges. Delegates have the privilege of the floor of the House of Delegates which includes the ability to submit resolutions, discuss and make motions on items of business and vote in elections.

2.0.1.3 Representation….

[subsequent sections will be renumbered accordingly]

2.1 Constituent Associations….

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2.1.3 ~~Certification~~ Credentialing. The president or chief executive officer of each constituent association, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA with the names and contact information of their delegates and alternate delegates ~~from their respective associations. Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

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

~~2.1.5 Vacancies.~~ ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

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

~~2.1.6.1 Term.~~ ~~Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term beginning as of the~~

~~date of certification of the delegate or alternate delegate by the constituent association to the AMA.~~

~~**2.1.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.~~

2.2 National Medical Specialty Societies….

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2.2.3 ~~Certification~~ Credentialing. The president or chief executive officer of each specialty society, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA with the names and contact information of their delegates and alternate delegates ~~from their respective societies~~. ~~Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

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

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

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

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

2.3.2 Apportionment. The total number of ~~M~~medical ~~S~~student r~~R~~egional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as ~~defined by~~ delineated in the rules of the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining ~~M~~medical ~~S~~student ~~Section~~ r~~R~~egional delegates

and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the ~~MSS~~ Medical Student Section Governing Council.

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

2.3.3 Election. Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. ~~Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees.~~ Regional d~~D~~elegates and alternate delegates shall be elected in conjunction with ~~at~~ the Business Meeting of the Medical Student Section associated with ~~prior to~~ the Interim Meeting of the House of Delegates. Regional d~~D~~elegates and alternate delegates shall assume their office ~~be seated~~ at the next Annual Meeting of the House of Delegates.

2.3.4 ~~Certification~~ Credentialing. The ~~Chair~~ Director of the Medical Student Section ~~Governing Council, or the Chair's designee,~~ shall provide ~~certify to~~ the ~~AMA~~ Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3 by December 5 of each year. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting occurring within their term as defined in 2.3.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

2.3.5 Term. Medical s~~S~~tudent r~~R~~egional delegates and alternate delegates shall be elected for one-year terms ~~and shall assume office on the date set by the Medical Student Section Governing Council~~.

2.3.6 Vacancies. A student who fills a vacancy for a regional medical student delegate must have been elected from the same medical student region as the vacating student and credentialed as a regional alternate delegate or a temporary delegate in accordance with Bylaws 2.3.3, 2.8.2, and 2.10.4. ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

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

2.4.1 Qualifications. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ must be active members of the Resident and

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

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

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

2.4.3 Election. Resident and fellow sectional ~~D~~delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section and approved by the Board of Trustees. Resident and fellow sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section prior to the Interim Meeting of the House of Delegates. Elected resident and fellow sectional delegates and alternate delegates shall assume their office at the next Annual Meeting of the House of Delegates. ~~Each delegate and alternate delegate must receive written endorsement from a society or organization currently seated in the House of Delegates and in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.~~

2.4.4 ~~Certification~~ Credentialing. The ~~Chair~~ Director of the Resident and Fellow Section ~~Governing Council or the Chair's designee~~ shall provide ~~certify to~~ the ~~AMA~~ Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3 by December 5 of each year ~~for the Resident and Fellow Section~~. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting within their term as defined in 2.4.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

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

2.4.6 Vacancies. A resident or fellow who fills a vacancy for a resident and fellow sectional delegate must have been elected by the Resident and Fellow Section and credentialed as a temporary delegate in accordance with Bylaws 2.4.3, 2.8.2 and 2.10.4. ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of the term.~~

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

2.6.1 ~~Certification~~ Credentialing. The president, chief executive officer, or other authorized individual of each entity shall provide ~~certify to~~ the AMA with the names and contact information of their respective delegate and alternate delegate at least~~. Certification must occur~~ 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates.

~~**2.6.2 Term.** Delegates from these entities shall be selected for 2-year terms, and shall assume office on the date set by the entity. Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of the House of Delegates.~~

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

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2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

2.8.2 ~~Certification~~ Credentialing. Alternate delegates shall be ~~certified~~ credentialed ~~to the AMA~~ in the same manner as delegates at least 45 days prior to each meeting of the House of Delegates.

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

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

~~**2.8.5**~~ **Rights and Privileges.** At the request of their corresponding delegate, ~~**a**A~~n alternate delegate may temporarily be seated for them ~~substitute for a delegate,~~ on the floor of the House of Delegates~~, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials~~. The alternate delegate must display their corresponding delegate's temporary credential and may then assume their privilege of the floor. ~~While substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote.~~

2.8.4

~~2.8.6~~ **Status.** The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates~~, n~~or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates upon the request of their corresponding delegate for whom they are ~~alternate delegate is substituting~~ temporarily seated.

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2.10 Registration and Seating of Delegates.

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

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

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

~~**2.10.4 Substitute**~~ **Temporary Delegate.** When a credentialed delegate or alternate delegate is unable to attend a meeting of the House of Delegates, or a portion thereof, the president~~, the president's designee~~ or the chief executive officer ~~other authorized individual~~ of the entity the vacating delegate represents, or their designee, may ~~appoint~~ credential a temporary ~~substitute~~ delegate or temporary ~~substitute~~ alternate delegate, who shall be eligible to serve as ~~such~~ a temporary delegate or temporary alternate delegate in the House of Delegates at that meeting only.

~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~

[Subsequent bylaw provisions will be renumbered]

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2.10.6
~~**2.10.8**~~ **Medical Student Seating.** Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate or temporary ~~substitute~~ medical student regional delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.

2.10.7
~~**2.10.9**~~ **Resident and Fellow Seating.** Each ~~delegate from the~~ ~~R~~resident and ~~F~~fellow ~~Section~~ sectional delegate shall be seated with ~~the physician's~~ their endorsing society or organization. ~~In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated.~~ Alternate or temporary ~~substitute~~ resident and fellow sectional delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Amendment to Opinion 1.1.1 “Patient-Physician Relationships”

EXECUTIVE SUMMARY

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians’ associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole. Ultimately, Opinion 1.1.1 “Patient-Physician Relationships” must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve. In light of these considerations, CEJA recommends amending Opinion 1.1.1.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 01-I-25*

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians' associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole.

At the 2025 Annual Meeting, testimony was heard that CEJA Report 06-A-25, "Amendment to Opinion 1.1.1 'Patient-Physician Relationships'," does not address "political and administrative influence" on the patient-physician relationship, and the report was referred back to CEJA.

In light of these considerations, CEJA has amended the body of the report and the recommendations to better reflect the reality of these external influences. As the first opinion of the *Code*, Opinion 1.1.1 is the foundation that supports all other *Code* opinions, many of which also address the important issues raised by the House. As the foundational opinion, Opinion 1.1.1 ought not be exhaustive and is not designed to address all of the important issues in the opinions that ultimately rely upon it.

BACKGROUND

Relevant House Policies

Several House policies reference the importance of the patient-physician relationship. Though not an exhaustive list, the following policies capture the spirit of the patient-physician relationship expressed within AMA House policy: H-165.837 "Protecting the Patient-Physician Relationship", H-225.950 "AMA Principles for Physician Employment", and H-275.937 "Patient/Physician Relationship and Medical Licensing Boards".[1–3] The patient-physician relationship as expressed by these policies is understood to be fundamental and paramount to the practice of medicine. This relationship is understood to carry certain obligations for physicians, including the duty to be patient advocates, to prioritize patient care, and be transparent regarding cost-sharing arrangements. Other considerations, including personal financial concerns, are to be secondary to the relationship. Furthermore, this relationship is not perceived as purely contractual, as termination of employment does not necessarily end the relationship between a physician and persons under their care (H-225.950).

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

Relevant Code Provisions

Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as: "fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering[… that is] based on trust" (Opinion 1.1.1).[4] This relationship is primarily represented as emerging from a physician's fiduciary duty to patients, in which both parties enter into this fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following opinions capture the spirit of the patient-physician relationship expressed within the *Code*: Opinion 1.1.1 "Patient-Physician Relationships", Opinion 1.1.3 "Patient Rights", Opinion 1.1.5 "Terminating a Patient-Physician Relationship", Opinion 1.1.6 "Quality", Opinion 1.1.7 "Physician Exercise of Conscience", Opinion 8.6 "Promoting Patient Safety".[4–9] These opinions demonstrate that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for the continuity of care, open communication, quality care, and trust.

In addition, the *Code* offers several opinions that highlight the importance of minimizing outside influence on the patient-physician relationship, such as political or administrative pressures that might negatively impact the relationship. Opinion 3.1.1 "Privacy in Health Care"[10] and Opinion 3.2.1 "Confidentiality"[11] underscore the importance of respecting patients' privacy and confidentiality in all clinical settings and the fundamental importance of doing so to maintain trust in the patient-physician relationship. Similarly, Opinion 11.1.1 "Defining Basic Health Care" states that physicians, both individually and collectively, share an obligation to "advocate for fair, informed decision making about basic health care that[…] [c]onsiders best available scientific data […] [and] seeks to improve health outcomes to the greatest extent possible"—focusing on the importance of science-based medicine and equity-focused policies regardless of political or administrative pressures to the contrary[12].

Opinion 11.2.1 "Professionalism in Health Care Systems" notes that models for financing and organizing the delivery of health care services can "pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships" and acknowledges, "[f]ormularies, clinical practice guidelines, decision support tools […], and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented."[13] To support physicians in upholding their ethical obligations, the Opinion states that all such tools should be designed in keeping with science-based medical practices and implemented fairly. This focus on equity is also supported by Opinion 11.2.7 "Responsibilities to Promote Equitable Care".[14] Lastly, Opinion 11.2.2 "Conflicts of Interest in Patient Care" states, "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients."[15] The Opinion concludes, "[w]here the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."[15] These opinions emphasize the importance that physicians be allowed to practice science-based medicine grounded in medical ethics without undue pressure from outside influences, including political or administrative pressures that might in any way prevent physicians from upholding their professional and ethical commitments. Regardless of external influences, and often in spite of them, physicians have an ethical duty to support the patient-physician relationship to the best of their ability.

ETHICAL ISSUE

Current guidance in Opinion 1.1.1 "Patient-Physician Relationships" focuses heavily on legal considerations about when a relationship is established and has little purchase on the ethical

concerns raised by extensive changes to the practice of medicine that have recently occurred. Among these changes are the continuing development of technology (such as augmented intelligence), the use of team-based care, the rising number of employed physicians (as contrasted with those in private practice), interference in the patient-physician relationship by third parties (such as health care administrators, insurers or government), and the recognition that physicians have an obligation to advocate for changes to institutions, policies, and practices in order to improve patient care and promote health care justice.

A major change to the patient-physician relationship over the past few decades has been an increased recognition of the importance of patient autonomy. Ironically, however, this move away from paternalism towards patient autonomy in the setting of the patient-physician relationship has taken place while medicine has come to be dominated by large institutions, financial concerns such as cost-containment, changes in financing designed to influence patient and physician behavior, commercialization, an increasing reliance on markets, and other pressures that have had a de-professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for both physicians and patients. Even as the discretionary space of physicians has shrunk, their responsibilities have expanded. Physicians are now called to engage in cultural competency and humility, trauma-informed approaches to care, and to recognize past harms and historical contexts of patient populations. They are called upon to be the mechanism by which medical inflation will be controlled. They are called upon to advocate not just only for their own individual patients within systems of care but to advocate for changes in the social systems that determine health care needs and distribute illness, injury, and disability unjustly.

Recognizing that each patient brings different experiences to the relationship is now seen as a crucial part of establishing trust within a patient-physician relationship. The question that arises, however, is how is that trust to be earned within systems that often appear untrustworthy and designed to frustrate the commitment of physicians to act for the good of their patients?

ETHICAL ANALYSIS

The patient-physician relationship is foundational for medical ethics. It is characterized by the nature of illness, the need for healing, and a commitment to help, culminating in a decision to take action directed toward healing and the alleviation of suffering caused by disease, injury, or disability. This relationship is inherently unequal. The patient is unavoidably in a position of vulnerability and dependency, while the physician holds the knowledge and the resources that the patient needs.[16] The sick, injured, and disabled therefore have little choice but to trust that their physicians will use the power of medicine for their good as individual patients. That trust is established by the physician's act of profession—the commitment, generally undertaken through an oath, to be worthy of patients' trust—and the patent's agreement to cooperative collaboration.

The heart of professionalism is thus the public commitment of physicians to use their medical knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first and foremost persons, true healing can only take place when the uniqueness and personhood of patients are taken into account, incorporating their biological particularities, beliefs, relationships, emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek care and be as candid as possible with their physicians.

All medical actions are oriented towards the ethical centrality of the patient-physician relationship. While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the

relief of medical suffering and provides healing in a holistic sense even when cure is not possible. Prevention is also oriented towards the good of individual patients and requires trust that interventions are appropriate for that aim. Public health efforts provide the common resources necessary to promote healing and prevent illness, injury, and disability, and thus unite societal commitments to justice and prevention of harm with physicians' duties of beneficence, nonmaleficence, and respect for persons.

This understanding of the patient-physician relationship makes medicine an inherently moral enterprise, qualitatively different from the commercial transactions of providers and consumers. The patient-physician relationship itself is part of the healing process and not a commodity or product. Even economists recognize that the demand for health care is substantially inelastic and nonfungible, placing it outside the assumptions of normative market economics. Medical knowledge is not property that physicians own. It is a social good built up by the work of generations of physicians, scientists, and researchers and made possible by the generosity of generations of patients who have contributed to the advancement of medical progress (and who, it is acknowledged, have not always consented to such participation).

Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political circumstances always condition the patient-physician relationship. Physicians, for instance, do not always live up to the ideals of the profession. Structural social inequities result in unequal access to health care. While the patient-physician relationship itself is not a market commodity, markets provide many of the goods and services that physicians rely on to care for patients. Unfortunately, this also means that these goods and services are subject to the vicissitudes and inequities inherent to market systems, sexism, racism, and other unjust forms of discrimination.

Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the distribution of physicians, the services they can provide for patients, the conditions under which physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the patient is the central moral focus of medicine, a commitment to justice will be required to ensure the integrity of the patient-physician relationship and to make the services of physicians available to all who stand in need of their care. In a pluralistic, liberal democracy, this requires, in turn, that professions be granted a relatively independent status outside other social institutions such as the market and the government. Too much encroachment by the market or the government into the legitimate authority of the medical profession ultimately undermines the central moral focus of medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation and respect for other social institutions, the medical profession itself can lose track of its own moral center. The good of the patient ought never to be made subservient to the political or financial ends of physicians, governments, or markets. Determining what the good of the patient is requires that physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows for patients to feel heard and respected.

As the profession of medicine continues to change, there are concerns about how these changes impact patient-physician relationships and thus the relevance of the patient-physician relationship itself. However, despite the evolving landscape of the medical profession, the patient-physician relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes to their roles that physicians face, clinical encounters will always be subject to the professional and ethical obligations that emerge from patient-physician relationships.

When we examine the patient-physician relationship, what we are really after is the source of the obligations that ground medical ethics. While medicine has always been practiced under non-ideal circumstances that can make it difficult to carry out these obligations to a maximal extent, we

recognize that current circumstances are making it more difficult than ever. Moreover, we recognize that a patient-physician relationship may arise in a variety of contexts, and that these may not always be geared towards benefiting the patient, the physician, or both. The goal of this report, however, is to outline the core aspects of ethical and just patient-physician relationships and articulate gaps in the current *Code* Opinion 1.1.1. in order to better support patients and physicians as the medical profession and health care ecosystems continue to evolve.

Trust and the Patient-Physician Relationship

The pressures of increasing de-professionalization and de-personalization in the healthcare environment have sometimes obscured or even seemed to denigrate the value of the patient-physician relationship. New ethical questions have arisen as systems of care have changed in ways that have made it more difficult for physicians to fulfil their duties that arise from a recognition that this relationship is central to the meaning and value of the profession. While the patient-physician relationship has responded and evolved in light of these challenges and in the face of other technological, economic, and sociocultural changes, there can be no doubt that patients' trust in medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the patient-physician relationship and new attempts to build the trust that sustains it.

Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who study trust have noted that the development of dyadic trust is a process that involves commitment, cooperation, and the building of confidence in benevolent values, motives, goals, and intentions.[17] Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal trust is also impacted by (and in turn impacts) social trust, as social trust influences the development of interpersonal trust which then also impacts trust in the institutions in which interpersonal interactions take place.[18]

To protect the patient-physician relationship, then, a central goal of the medical profession should be to foster trust in health care, which has been in sharp decline for the past half century.[19] One of the primary means to engender trust is through good communication. Research has shown that aspects of physician communication can impact patient outcomes (such as medication compliance) and patient satisfaction (which is associated with greater continuity of care), and that patient-centered approaches to care, which consider the patient's perspective on equal ground with the physician's clinical diagnosis, enhance communication and the patient-physician relationship.[20]

Fostering Trust to Support the Patient-Physician Relationship

Research on physician communication practices have found at least five broad communication categories including: information giving, information seeking (questioning), partnership building, rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional content), and socioemotional behaviors.[21] How patients and physicians view these aspects of communication, and the patient-physician relationship in general, are not always the same, however. In one study comparing physician and patient evaluations of the relationship, researchers found that while physicians identified their technical expertise and knowledge as vital for establishing trust in the relationship, emphasizing the importance of competence, devotion, serviceability, and reliability, patients stressed the importance of interpersonal skills as more important, such as caring, appreciation, and empathy.[22] Recognizing this difference in perceptions is crucial for understanding how trust can be gained or lost, especially considering that researchers found trust to make the largest contribution to patient-physician perceived satisfaction.[22]

Patient satisfaction is strongly associated with positive physician communication behaviors. Because physicians' communication behaviors vary widely, however, there is significant room here for improving patient-physician relationships. One study found that only 33% of physicians were rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair" or "poor" on all four behaviors.[23] Patient-physician communication is one of the strongest factors that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust.[24]

Communication is not the only value that engenders and supports trust. Research has found that clinicians whose patients expressed trust in them worked in environments that placed an emphasis on quality, communication, clinical cohesion, and alignment of values between clinicians and organizational leaders.[25] Like communication, physician empathy has also been regarded as central to patient-centered care, and research has found that empathy correlates with patient satisfaction, adherence, outcomes, and enablement.[26] Other models of trust establish foundational factors that include competency, motive, and transparency.[19]

The Future of Patient-Physician Relationships

When considering the source of the ideal patient-physician relationship, its emergence is simultaneously contractual, dependent on virtues, and relational. All three of these conceptual models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency, transparency, aligned motives, and continuity. These values in many ways become ideal virtues within health care that help create trust in the institution of medicine over time, which is crucial for initial clinical encounters as well as for individuals who lack capacity. Regardless of external influences, such as political or administrative pressures, physicians have a responsibility first and foremost to their patients and to supporting the patient-physician relationship. When these influences create conflicting priorities, physicians should ensure that their actions align with their professional and ethical obligations.

Physicians have an ethical duty to support the patient-physician relationship by upholding the virtues of the profession. This ethical duty is grounded in medical professionalism and the commitment to serve as healers. The relationship that patients and physicians enter into is sustained by trust—in both the profession as whole, as well as in both the patient and the physician who agree to participate in a cooperative and collaborative partnership. This trust gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest. This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in importance with respect to both individuals' contributions to the relationship; similarly, the relationship is not a commodity product, yet it involves interacting with market economics. The patient-physician relationship is contextual—biological, historical, socioeconomic, and political elements will always be relevant—but it is also fundamentally a moral activity.

Honavar writes, "[the p]atient–physician relationship is a complex psychosocial interplay of vulnerability, trust, and authority in a professional setting".[27] Currently, the *Code* primarily speaks to the importance of trust within the patient-physician relationship without acknowledging that the reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power dynamics of every patient-physician relationship will be different, of course, but it is crucial that the *Code* address such concepts as patient vulnerability, the importance of respect, communication, and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships,

the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve.

RECOMMENDATION

Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed.

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~~ The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilit~~y~~ies to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship ~~exists~~ commences when a physician begins to serve 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:~~ The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.

~~(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.~~

(Modify HOD/CEJA Policy)

Fiscal Note: Minimal

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REPORT 02 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

EXECUTIVE SUMMARY

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

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-25

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

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

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

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

The House testified against the word "could" in recommendation (c) of CEJA Report 8-A-25, noting that its use is too broad, nonspecific, and might restrict physicians' ability to take collective action. CEJA appreciates that the use of "could" created an insurmountable bar, and so as a result, in recognition of physicians' fiduciary duties and the need for physician advocacy, CEJA has reached a balance by changing "could" to "would likely" in recommendation (c) for greater clarity.

BACKGROUND

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

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percent of practicing physicians.[1] Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

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

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

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

Relevant Laws

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

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

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

Relevant AMA Policy Provisions

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

Relevant Code *Provisions*

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

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

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

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised.[12] The opinion

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

Additional Relevant Policy

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

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

ETHICAL ISSUE

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

REVIEW OF RELEVANT LITERATURE

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

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the

collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable.[6,13,18,19,20] However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income.[6,18]

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

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

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

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

> Whatever justification they may have, strikes or "slow downs" by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the medical profession has thus been compromised by physicians themselves. Those who choose to

> pursue self-interest, as union members may, cannot at the same time demand a superior moral position in society.[22]

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

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

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

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care,[25-28] much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.[26,27] Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes.[25] Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain[28] This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution.[29]

ETHICAL ANALYSIS

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

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the health care sector has seen an increase in the complexity of health care systems, the transition to a majority physician

employment structure, and as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other non-physicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

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

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

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

CONCLUSION

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.

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

(d) Physicians may consider engaging in disruptive forms of collective action that do not compromise patient care only as a last resort, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

(e) Disruptive actions, including strikes, that could directly compromise patient care should be avoided and should not be used solely for physician self-interest.

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

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

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

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-I-25

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.949, "Ethical Impetus for Research in Pregnant and Lactating Individuals," was adopted at the 2024 Annual Meeting and asks "that our Council on Ethical and Judicial Affairs (CEJA) consider updating its ethical guidance on research in pregnant and lactating individuals."

BACKGROUND

More than four million individuals give birth in the United States every year[1] and 70 percent of these individuals will require at least one prescription medication while pregnant.[2] Despite the widespread use of medications during pregnancy, most information about the efficacy and safety of medication used during pregnancy comes from the post-marketing setting and is not derived from clinical research trials.[3]

Only a dozen medications have been approved by the United States Food and Drug Administration (FDA) for use during pregnancy, and those medications are for gestation- or birth-related medical issues.[4] Therefore, any medications utilized to treat chronic health conditions in pregnancy are used without FDA approval ("off label"). Only 2.4 percent of those commonly used medications for chronic health conditions have included pregnant individuals in controlled human clinical trials. The lack of clinical trial data is a result of the historical exclusion of pregnant and lactating individuals from clinical trials. Exclusion of pregnant and lactating individuals from clinical trials has often occurred due to the fear of harming the fetus or newborn, as well as concern that physiologic changes in pregnancy or during lactation will impact the results of pharmacologic trials.[3,5] The effect of this exclusion is that physicians and patients are forced to make decisions about whether to utilize medications during pregnancy without adequate fetal and maternal safety data.[6]

ETHICAL ISSUE

Pregnant and lactating individuals have been systematically excluded from clinical trials for decades out of concern for negative effects on fetuses and nursing infants. This exclusion has resulted in a paucity of evidence regarding safe and effective medication use in these groups of individuals. Due to the existing knowledge gaps surrounding the use of medications during pregnancy and breastfeeding, physicians and patients are faced with making treatment decisions without appropriately understanding the potential benefits and risks to both the pregnant individual and their fetuses or nursing infant. Additionally, these knowledge gaps prevent physicians from

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being able to appropriately counsel pregnant patients regarding the risks, benefits, and alternatives of treatments. At issue is how to balance respect for pregnant and lactating individuals with the potential benefits and harms of research.

REVIEW OF RELEVANT LITERATURE

Pregnant and lactating individuals have historically been considered "vulnerable" and subjected to additional research protections and exclusion from research.[7] This problem is known as the "protection-inclusion dilemma", whereby groups deemed "vulnerable" are "over-protected" and excluded from research, leading to justice issues including a "lack of relevant health data for under-represented populations."[8] The consequence of the protection-inclusion dilemma is that most of the medications pregnant individuals are prescribed are not FDA approved for pregnancy. This is problematic because while "there are significant physiologic changes in pregnancy, including near doubling of maternal blood volume and alterations in binding proteins, the pharmacokinetics [PK] and efficacy of drugs in pregnancy are, by and large, unknown."[7] This uncertainty for prescribers results in dosages labelled for use in nonpregnant individuals being used for pregnant individuals, "with little consideration for the PK changes that occur during pregnancy."[9]

Although the negative effects of excluding pregnant and lactating individuals in clinical trials have been noted for years, little has been done in that time to address the significant knowledge gaps in research that remain. For example, many Institutional Review Boards (IRB) "continue to regard pregnancy as a near-automatic cause for exclusion, regardless of the costs of exclusion or the magnitude or likelihood of the risks of participation," and the lack of research data leads to persistent disparities for chronic disease management among pregnant individuals.[5]

Relevant Laws

The FDA has several relevant regulations. 45 CFR 46, Subpart B "Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research", provides regulations regarding research involving pregnant individuals. 45 CFR §46.204 – "Research involving pregnant women or fetuses" states that:

> Pregnant women or fetuses may be involved in research if all of the following conditions are met:
>
> (b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means.[10]

Additionally, as of January 21, 2019, the Common Rule no longer labels pregnant individuals as "vulnerable" with regards to IRBs. This is because while pregnant individuals have historically been deemed vulnerable, it has since been recognized that while some individuals who are pregnant may be vulnerable, being pregnant in and of itself does not automatically denote vulnerability. [11,12] The 2024 updated version of the World Medical Association's Declaration of Helsinki reinforces this point, stating that "[w]hen such individuals, groups, and communities have distinctive health needs, their exclusion from medical research can potentially perpetuate or exacerbate their disparities. Therefore, the harms of exclusion must be considered and weighed against the harms of inclusion."[11]

Relevant Code Provision(s)

The *Code of Medical Ethics* encourages the inclusion of pregnant individuals in clinical trials, when appropriate, so long as the research "balance[s] the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies" (Opinion 7.3.4). However, the *Code* also places constraints on physicians involved in maternal-fetal research, advising that they should "[e]nroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus" (Opinion 7.3.4).

ETHICAL ANALYSIS

A multitude of historical, legal, scientific, and societal factors have resulted in the exclusion of pregnant and lactating individuals from clinical trials for decades. However, the ethical principle of justice necessitates that the benefits and burdens of research participation be fairly distributed across all groups, including pregnant and lactating individuals, because failure to do so produces disparities that impact both safety and quality of care for pregnant and lactating individuals, fetuses, and nursing infants.

Concerns for fetal safety have served as the primary justification for the exclusion of pregnant individuals from clinical trials for decades, but this exclusion has paradoxically resulted in substantial maternal and fetal harm. Because information about toxicity and dosing for pregnant and lactating individuals has not been determined through smaller scale and well-controlled clinical trials for most medications, far more pregnant and lactating individuals who require medications for chronic medical conditions are being exposed to potentially harmful medications via "off label" uses.

Examples of this harm can be seen in the historical use of thalidomide and diethylstilbestrol in pregnant individuals. While the tragic consequences of their use have been cited as reasons to exclude pregnant individuals from clinical trials, it was actually the lack of controlled data from clinical trials that caused such widespread detrimental effects due to the teratogenic effects of these drugs not being examined until post-marketing surveillance data was available. Had smaller scale and better controlled clinical trials been conducted, mass marketing and exposure to these medications for pregnant individuals may have been avoided because the teratogenic effects would have been discovered during trials.[13]. Another example is that of ACE inhibitors, which were used in pregnant individuals for three decades prior to the 1996 discovery that its use in the first trimester can cause congenital anomalies.[5]. Had it been studied more rigorously through smaller scale clinical trials with individuals consenting to the risks of participating in research, this discovery may have been made much sooner and far fewer individuals would have been exposed to this drug in the first trimester without knowing the risks of doing so.

Historically, concern for pregnant individuals and fetuses has centered on defining this population as "vulnerable", thus needing broad shielding from risks, such as medical research. Such an approach to research practices has been deemed "overly paternalistic, disempowering, or coercive."[14] Pregnant and lactating individuals are not automatically vulnerable, and this approach does not respect their autonomy to assess the benefits and risks of participation for themselves and their fetuses or newborns.[15] Pregnant and lactating individuals should always be provided the opportunity to decide whether research participation is in their best interest through informed consent. If pregnant or lactating individuals are unable to be included in research, alternative ways to rectify any gap in knowledge should be developed. For example, pregnant and lactating

individuals should be instructed on how to participate in research registries and adverse event reporting programs.

CONCLUSION

The historical exclusion of pregnant and lactating individuals from clinical trials has resulted in a lack of data about the appropriate safety, dosage, and efficacy of most medications in this group. This knowledge gap has created an ethical imperative to include more pregnant and lactating individuals in clinical trials. While consideration of maternal, fetal, and nursing infant well-being should be important criteria included in guidelines for research, wholesale exclusion of pregnant and lactating individuals from clinical trials comes with its own risk to fetal and maternal safety. Theoretical risks for fetal harm should not automatically be assumed to outweigh potential risks of ongoing nonparticipation. Currently, the *Code* does not reference this disparity. Nor does it refer to lactating individuals. It also does not contain gender neutral language, i.e., it references women and not individuals.

RECOMMENDATION

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

1. Research involving pregnant and lactating individuals, including but not limited to, research regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses or nursing infants, must balance the health and safety of individuals who participate and the well-being of their fetuses or nursing infant against the desire to develop new and innovative therapies. Although it is important to carefully consider potential fetal risks involved when pregnant and lactating individuals participate in research, it is critical to realize that large scale exclusion from participation by these individuals has also precluded potential benefits and in some cases resulted in harm for this group. The paucity of data on safe and effective medical treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing between pursuing medical interventions with uncertain risks to themselves and their fetuses or nursing infants, or foregoing the interventions altogether, which might itself cause harm due to undertreatment of medical conditions.

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

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

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

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

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

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

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

2. AMA Policy D-140.949 be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-25)

Introduced by: New England Delegation

Subject: Clarifying Conscientious Objection

Referred to: Reference Committee on Ethics and Bylaws

Whereas, recent high-profile cases of conscientious objection have involved physicians refusing care to patients based upon their identity characteristics, including a child who was refused care because their parents' sexuality and a mother who was refused prenatal care because they were unmarried; [1-2] and

Whereas, present AMA policy, by limiting conscientious objection only where it constitutes discrimination against or an undue burden on patients, tacitly permits the use of conscientious objection in the aforementioned cases; and

Whereas, in spite of AMA policy asking physicians to "take care that their actions do not discriminate against…individual patients," conscientious objection has long been invoked to refuse care to patients based upon protected characteristics, including gender identity and sexuality; [3-5] and

Whereas, in spite of the fact that AMA policy clear places limits on conscientious objection, such limits are frequently not reflected in state or federal law or policy; [6-8] and

Whereas, by limiting conscientious objection where it constitutes discrimination, present AMA policy is dependent on the legal definition of discrimination, and a change in the legal definition of discrimination would thereby change where conscientious objection is permissible; and

Whereas, the revocation of federal protections for LGBTQ+, gender-diverse, or disabled populations would thereby render it permissible, per present AMA policy, for physicians to conscientiously object to providing care to patients in these populations; and

Whereas, the ethical principles which underlie medical practice are beholden to no law; and

Whereas, the use of conscientious objection to refuse care to patients based upon their membership in particular groups, rather than an ethical objection to providing a particular type of care, is widely regarded as unethical by philosophers of medicine; [9-11] therefore be it

RESOLVED, that our American Medical Association study the use of conscientious objection to refuse care to patients based upon their membership in particular groups, including when such refusal does not meet the legal standard of invidious discrimination, and return recommendations strengthening present policy against this practice (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the Council on Ethical and Judicial Affairs to consider amending the AMA Code of Medical Ethics--including, but not limited to, its relevant Principles--to ensure

that a physician's right to choose their patients is appropriately limited by their duty to provide equitable access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA (i) support efforts to include protections for patients, as they are delineated in the AMA Code of Medical Ethics, in state- and federal-level policies codifying conscientious objection and (ii) oppose policies protecting conscientious objection which do not also provide these protections to patients. (New HOD Policy)

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

Received: 9/18/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-25)

Introduced by: Women Physicians Section

Subject: Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters

Referred to: Reference Committee on Ethics and Bylaws

Whereas, wearable smart devices with discreet recording capabilities, such as Ray-Ban Meta glasses and other similar technologies, are increasingly accessible to physicians and patients alike; and

Whereas, these devices may have always-on or easily activated photo, audio, or video recording functionality that can be difficult to detect, potentially enabling covert documentation of clinical encounters; and

Whereas, existing healthcare technology companies report an interest in integrating popular artificial intelligence scribes with wearable smart devices[1]; and

Whereas, AMA Ethics Opinion 3.1.3, "Audio or Visual Recording Patients for Education in Health Care," outlines necessary consent and privacy protections for educational recordings, but does not explicitly address personal, wearable, or commercial recording devices used by individual clinicians or patients in routine care; and

Whereas, patients have a reasonable expectation of privacy in the clinical setting, and undisclosed recording—whether by the clinician or patient—risks undermining trust in the physician-patient relationship, violates ethical norms, and may conflict with state or federal law; and

Whereas, sensitive physical examinations, including breast, pelvic, genital, and rectal exams, require heightened attention to patient dignity and privacy, and the presence of wearable recording devices during such exams—even if not actively recording—may compromise patient trust and comfort; and

Whereas, there is currently no clear AMA policy guiding the ethical and privacy considerations for physician-worn recording devices outside of institutional educational or telehealth settings; therefore be it

RESOLVED, that our American Medical Association consider developing new ethical guidance to address the use of personal or wearable recording devices—including eyeglass-mounted cameras—by physicians and patients in clinical encounters, including provisions that:

a. Require informed patient consent prior to any recording,
b. Prohibit covert or undisclosed use of such devices in clinical care,
c. Recommend that such non-clinical visual recording devices not be worn during physical examinations of the breast, pelvic, genital, or rectal areas, regardless of recording status.

(Directive to take Action); and be it further

RESOLVED, that our AMA work with appropriate entities and organizations to develop model institutional policies on the ethical use, disclosure, and documentation of wearable and ambient personal recording technologies in health care settings. (Directive to Take Action)

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

Received: 9/25/25

REFERENCES

1. https://getvim.com/blog/ambient-scribe/

RELEVANT AMA POLICY

3.1.3 Audio or Visual Recording Patients for Education in Health Care

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:

a. Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
b. Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
c. Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
    i. about the purpose of recording, the intended audience(s), and the expected distribution;
    ii. about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
    iii. that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
    iv. that the patient may withdraw consent at any time and if so, what will be done with the recording;
    v. that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
d. Ensure that the patient has had opportunity to discuss concerns before and after recording.
e. Obtain consent from a patient (or the authorized decision maker):
    i. prior to recording whenever possible;
    ii. before use for educational purposes when consent could not be obtained prior to recording.
f. Respect the decision of a patient to withdraw consent.
g. Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.
h. Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.
i. Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
j. Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records. [Issued: 2016]

3.1.4 Audio or Visual Recording of Patients for Public Education

Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld. Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).

Physicians involved in recording patients for public broadcast should:

(a) Participate in institutional review of requests to record patient interactions.
(b) Require that persons present for recording purposes who are not members of the health care team:
    (i) minimize third-party exposure to the patient's care; and
    (ii) adhere to medical standards of privacy and confidentiality.
(c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
(d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
(e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(f) Inform a patient (or authorized decision maker) who is to be recorded:
    (i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
    (ii) about the intended audience(s);
    (iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
    (iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
    (v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
    (vi) whether the physician was compensated for his participation and the terms of that compensation.
(g) Ensure that the patient has had the opportunity to address concerns before and after recording.
(h) Ensure that the patient's consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
(i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patient's care) perceives that recording may jeopardize patient care.
(j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
(k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-25)

Introduced by: Women Physicians Section

Subject: Report on Gender-Based Pay Equity in Medicine

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the American Medical Association (AMA) has established several policies aimed at addressing gender-based pay equity within the medical profession, reflecting a commitment to ensuring fair and equitable compensation for all physicians, regardless of gender; and

Whereas, the AMA's policies emphasize the importance of pay equity, transparency in compensation, support for research and data collection, education and advocacy, workplace policies, and support for female physicians (AMA Policy D-65.989, H-65.961, and E-9.5.5); and

Whereas, multiple studies have demonstrated persistent gender-based pay disparities in medicine, with female physicians earning approximately $2 million less than their male counterparts over a 40-year career, even after adjusting for specialty, hours worked, and experience; and

Whereas, these disparities negatively impact the morale, retention, and advancement of female physicians, and contribute to broader issues of equity and diversity within the profession; and

Whereas, transparency and accountability are essential for identifying and rectifying pay disparities, as supported by AMA policies and recommendations from national organizations such as the National Academy of Medicine; therefore be it

RESOLVED, that our American Medical Association study and report at HOD 2026 the current pay structures and existing disparities between male and female physicians, and review policies to ensure equitable compensation for all physicians. (Directive to Take Action)

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

Received: 9/25/25

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2. American Medical Association. Policy D-65.989, H-65.961, E-9.5.5.
3. National Academy of Medicine. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. 2019

RELEVANT AMA POLICY

D-65.989 Advancing Gender Equity in Medicine

1. Our American Medical Association will:
    a. advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation.
    b. advocate for pay structures based on objective, gender-neutral criteria.
    c. encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians.
    d. advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias:
    a. Elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice.
    b. Create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act.
    c. Establish educational programs to help empower all genders to negotiate equitable compensation.
    d. Work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings.
    e. Create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
5. Our AMA will:
    a. require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA.
    b. work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership. [Res. 010, A-18; Modified BOT Rep. 27, A-19; Appended: Res. 615, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-25)

Introduced by: Connecticut

Subject: Patient Options to Restrict Secondary Use of Their Healthcare Data

Referred to: Reference Committee on Ethics and Bylaws

Whereas, health data and protected health information (PHI) that are de-identified per Department of Health and Human Services (HHS) guidelines are no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and may be lawfully aggregated and shared for secondary use[1,2]; and

Whereas, large de-identified patient datasets are critical for studies of rare diseases, health disparities, and population-wide trends, and their availability enables augmented intelligence innovation, expands access to precision medicine, enhances interoperability, and advances equitable patient-centered healthcare[3-11]; and

Whereas, de-identified data is typically controlled by the entity that performs the de-identification, reinforcing institutional control over de-identified derivatives and decreasing autonomy in patients' control over their own data and its secondary use[12-14]; and

Whereas, HHS acknowledges that data de-identified via by its guidelines still retains a non-zero risk of re-identification, which has been subsequently proven in medical literature, running the risk for potential submission of fraudulent medical claims, leakage of PHI, and loss of trust in healthcare organizations[15-20].; and

Whereas, entities that control de-identified data may freely sell this data for-profit to external organizations without patient consent, a multi-billion dollar industry and practice that is detrimental to patients by placing them at risk of re-identification without allowing for autonomous control over secondary use of their own data[21-23]; and

Whereas, data privacy practices acknowledging that all data collected on an individual can present risks, and establishes that individuals control access to their own health data (access, use, sharing) have been implemented successfully under the EU's General Data Protection Regulation (GDPR)[24-29]; and

Whereas, these practices allow patients' right to control their data to coexist with large-scale research infrastructures that preserve privacy like OpenSAFELY, which has supported numerous peer-reviewed studies using secure and auditable access to EHRs while allowing individuals to request that organizations delete personal data on the basis of withdrawing consent, thereby restricting secondary data use[25-30]; and

Whereas, it is logically and ethically reasonable to argue for the continued use of appropriately de-identified data for research, as the potential benefits (robust research, equitable innovation, precision care) justify the privacy hazards; and

Whereas, preserving patients' autonomy to restrict secondary use of their data from use in these efforts is an implementable solution that address the non-zero re-identification risk of de-identified data and advances patient-directed healthcare; therefore be it

RESOLVED, that our American Medical Association support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including the ability to retroactively withdraw their data from de-identified data sets. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

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RELEVANT AMA POLICY

D-478.996 Information Technology Standards and Costs

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

[Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20; Reaffirmation: A-22; Reaffirmed: A-23]

D-478.995 National Health Information Technology

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure,

while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:
    a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
    b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
    a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
    b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

[Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed:

BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmation: Res. 715, A-24; Reaffirmed: Res. 802, I-24]

H-315.962 Research Handling of De-Identified Patient Information
Our American Medical Association supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. [BOT Rep. 16, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 07, A-24]

H-480.931 Assessing the Intersection Between AI and Health Care
Augmented Intelligence Development, Deployment, and Use in Health Care

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

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
    c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
    d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.

2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:
1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v. Data privacy.

vi. Cybersecurity.
vii. Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:
i. Users should be provided with training specifically on generative AI. Education should address:
1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.

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

7. Augmented Intelligence Cybersecurity
a. AI systems must have strong protections against input manipulation and malicious attacks.
b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

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

the responsibility of the authors to validate the veracity of any referenced content generated by AI.

f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

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

(or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

[BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

H-406.987 Medical Information and Its Uses

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19]

H-315.983 Patient Privacy and Confidentiality

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
    c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
    d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and

   e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms:
   a. that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
   b. that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
   c. that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
   a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
   b. Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
   c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
   d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health

research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
    a. the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
    b. the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
    c. the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

[BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18 Reaffirmation: I-18 Reaffirmed: Res. 219, A-21 Reaffirmed: Res. 229, A-21 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: BOT Rep. 22, A-22 Reaffirmation: A-23 Reaffirmed: CSAPH Rep. 08, A-24]

H-450.933 Clinical Data Registries

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.
2. Our AMA encourages national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries.
3. Our AMA supports flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients:

a. Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data.
b. Data elements, risk-adjustment models and measures used in the registry should be fully transparent.
c. Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level.
d. Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner.
e. Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry.

4. Our AMA encourages physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices.
5. Our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of physician practice participation in clinical data registries.
6. Our AMA supports that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles:

a. Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services.
b. Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information.
c. Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
d. Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to

their patients.
e. When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.
[CMS Rep. 8, A-14; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 06, A-18; Reaffirmed: CSAPH Rep. 2, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-25)

Introduced by: Young Physicians Section

Subject: Preserving Autonomy in the Patient-Physician Relationship

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the patient physician relationship is core of our role as physicians; and

Whereas, our American Medical Association Code of Medical Ethics is intended to detail the ethical responsibilities of physicians across specialties and there is extensive AMA policy on many of these topics, but some of these key issues are not directly addressed in the Code; and

Whereas, the ethical responsibilities of physicians have continued to become more complex as physicians have moved from an environment of more heavily private practice to employed physicians. This comes with a greater potential for influence on the patient physician relationship as supervisors may be acting as fiduciaries of the institution rather than in the clinical interest of the patient. Current policy speaks to the potential of a physician to willingly enter into entanglements that they have chosen, but does not speak to the modern realities of physicians in some cases being forced into ethically dubious situations by an employer with whom they may be contractually obligated to remain employed; and

Whereas, there is an increasing possibility of undue influence in the patient physician relationship as medical practices have been purchased by investment groups. This could potentially lead to provision of more costly treatment, as is mentioned in the Code but also withholding expensive or poorly reimbursed interventions; and

Whereas, there has been increasing political attention to discussions in the clinical examination room between physicians and patients and the Code does not discuss external political influences on this relationship though AMA policy on this subject is robust; and

Whereas, trust in the patient physician relationship is paramount in providing high quality clinical care and even the suggestion of influence can cause a loss of trust; therefore be it

RESOLVED, that our American Medical Association study relevant sections of the *Code of Medical Ethics* to address outside political and administrative influences on the patient physician relationship and its impact on shared decision making in the clinical setting. (Directive to Take Action)

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

Received: 9/25/25

REFERENCES

1. American Medical Association. (2017, February 17). Ama Praise Court ruling on Florida gun gag law. https://www.ama-assn.org/press-center/ama-press-releases/ama-praise-court-ruling-florida-gun-gag-law
2. American Medical Association. (2016). Issue brief: Protecting the patient-physician relationship. https://www.ama-assn.org/system/files/protecting-patient-physician-relationship-issue-brief.pdf
3.American Medical Association, Council on Constitution and Bylaws (2023). Responsibilities to Promote Equitable Care

RELEVANT AMA POLICY

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association
   opposes the interference of government in the practice of medicine,
   including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
   a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
   b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
   c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
   d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter. [Res. 523, A-06; Appended: Res. 706, A-13; Reaffirmed: Res. 250, A-22]

Government Interference in Patient Counseling H-373.995

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

[Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19; Modified: Speakers Rep. 02, I-24]

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of our American Medical Association:

1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

[Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; reaffirmed by Rules and Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13; Reaffirmed: CEJA Rep. 05, A-23; Modified: Speakers Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-25)

Introduced by: Resident and Fellow Section

Subject: Amendment to AMA Bylaws to Enable Continuity of Leadership

Referred to: Reference Committee on Ethics and Bylaws

Whereas, per the AMA Resident and Fellow Section IOPs, the Governing Council includes the Immediate Past Chair who serves an ex-officio, non-voting member; and

Whereas, the role of the Immediate Past Chair is to provide continuity of the leadership of the Section; and

Whereas, the Immediate Past Chair serves a 6-month term between the Annual and Interim Assembly Meetings after first serving a 6-month term as Chair-Elect and a 1-year term as Chair; and

Whereas, the Chair-Elect has often spent at least one year as a member of the Resident and Fellow Section prior to being elected; and

Whereas, some members of Resident and Fellow Section may only be part of the Section for 3 years, including Family Medicine, Internal Medicine, and Pediatrics residents who do not immediately pursue fellowship; and

Whereas, given this election structure and these training timelines, the Chair-Elect may no longer be in training by the time they would start their term as Immediate Past Chair; and

Whereas, current AMA bylaws specify that all Resident and Fellow Section Governing Council members including Immediate Past Chair must be a current resident or fellow; and

Whereas, the RFS Assembly has formally requested via >⅔ vote that the Immediate Past Chair be allowed to serve their term even as a graduate of the RFS so that the Section may benefit from continuity in leadership; therefore be it

RESOLVED, that our American Medical Association amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

RELEVANT AMA POLICY

Resident and Fellow Section - Cessation of Eligibility B-7.1.2
If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member completes residency or fellowship within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

AMERICAN MEDICAL ASSOCIATION

Resolution: 007
(I-25)

Introduced by: California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington, American College of Obstetricians and Gynecologists

Subject: Improving Protection for Reproductive Health Information

Referred to: Reference Committee on Ethics and Bylaws

Whereas, existing AMA policies oppose the criminalization of accessing abortion services (H-5.980) and supports preservation and expansion of access for abortion services (D-5.996, D-5.999); and

Whereas, the 2024 federal regulatory modifications to the HIPAA Privacy Rule strengthen the protection of reproductive health information by prohibiting the use or disclosure of Protected Health Information (PHI) for criminal, civil, or administrative investigations or liabilities related to lawful reproductive health care[1]; and

Whereas, the enforcement of such privacy protections ensures that individuals can access reproductive health services without fear of legal repercussions; and

Whereas, the criminalization of reproductive health care has affected both patients and physicians[2], leading to interference in the practice of medicine and poor patient outcomes[3]; and

Whereas, this issue is urgent because these 2024 regulatory improvements are now being challenged in court or could be withdrawn by the Trump Administration in the near future[4] ; therefore be it

RESOLVED, that our American Medical Association support the prohibition against the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability for the mere act of seeking, obtaining, providing, or facilitating reproductive health care. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30925

REFERENCES
1. https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html
2. https://www.pbs.org/newshour/health/new-york-doctor-indicted-over-online-prescription-of-abortion-pill-in-louisiana
3. https://www.npr.org/2023/09/12/1199068710/patients-and-doctors-in-3-states-announce-lawsuits-over-delayed-and-denied-abort
4. https://www.hipaajournal.com/texas-judge-vacates-hippa-reproductive-healthcare-privacy-rule/

RELEVANT AMA POLICY

Oppose the Criminalization of Self-Managed Abortion H-5.980

1. Our American Medical Association opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services.
2. Our AMA will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions.
3. Our AMA will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

[Res. 007, A-18 Modified: Res. 027, A-22]

Expanding Support for Access to Abortion Care D-5.996

1. Our American Medical Association will advocate for:
    a. broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs.
    b. explicit codification of legal protections to ensure broad, equitable access to abortion services.
    c. equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

[Res.229, I-22]

Preserving Access to Reproductive Health Services D-5.999

1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA 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, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA 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. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA 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.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

[Res. 028, A-22 Reaffirmed: Res. 224, I-22 Modified: BOT Rep. 4, I-22 Appended: Res. 317, I-22 Reaffirmation: A-23 Appended: Res. 711, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-25)

Introduced by: College of American Pathologists

Subject: Health Plan In-Network Steering of Pathology/Laboratory Services

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the referral of pathology and laboratory specimens to in-network laboratories and pathologists should be at the exclusive discretion of referring physician's medical judgment to achieve best patient care; and

Whereas, the referral of pathology/laboratory specimens to in-network pathologists and laboratories should, under the AMA Code of Medical Ethics, ("Consultations, Referrals, and Second Opinions") be based "upon the patient's medical needs", or relevant medical factors, including convenient patient access, turnaround time, clinical expertise of the pathologist/laboratory for the specimen referred, and pathologist/laboratory unimpeded ease of consultation (i.e. clinical integration) with the medical system or medical practice of the ordering clinician; and

Whereas, health plan payers are now tiering and limiting laboratory in-network referrals and patient access across a suite of insurance products, including Medicaid Managed Care and within the state health insurance exchanges, by promulgating and enforcing contractual policies that deny ordering physicians the exercise of medical discretion and choice, and requiring referrals to "preferred" or "designated" in-network laboratories, which may even be a single designated laboratory; and

Whereas, health plan steering to a single laboratory and other specimen referral limitations to only certain in-network providers of pathology and laboratory services is contrary to the optimal practice of medicine and the medical interest of patients, disrupting local and regional health care delivery systems; therefore be it

RESOLVED, that our American Medical Association support state and federal legislative efforts to expressly prohibit in-network steering by health insurance plans, or by laboratory benefit managers under contract with such plans, to "preferred" or "designated" in-network laboratories or pathologists, thereby excluding other in-network pathology and laboratory providers (New HOD Policy); and be it further

RESOLVED, that our AMA advocate in partnership with state medical societies and medical specialty societies to protect ordering physician discretion to refer pathology and laboratory specimens to any in-network pathologist or in-network laboratory of their choice, based upon relevant medical considerations in the best interest of patient care, consistent with AMA Code of Medical Ethic. (Directive to Take Action)

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

Received: 9/30/25

REFERENCES

RELEVANT AMA POLICY
Laboratory Benefit Managers H-260.962
1.2.3 Consultation, Referral & Second Opinions

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-25)

Introduced by: New England Delegation

Subject: Gender Equity in Disability Insurance for Physicians

Referred to: Reference Committee on Ethics and Bylaws

Whereas, disability insurance is a critical component of financial security for physicians, providing income protection if they are unable to work due to illness or injury. Research suggests that one in seven doctors will need disability insurance at some point in their careers.[1] Despite its importance, a significant disparity exists in disability insurance rates between male and female physicians, with women often charged premiums that are 40−50% higher for the same coverage. This gender-based pricing is rooted in outdated assumptions and statistical data that fails to account for the evolving role of women in medicine and the nuanced reality of modern-day health care practices[2]; and

Whereas, historically, insurance providers have relied on demographic data suggesting women may experience higher disability rates, often due to caregiving roles outside of work.[2] However, this model does not account for the increasing number of women in diverse specialties, leadership roles, and without the previous gender-based barriers. Today, women represent nearly 40% of all physicians in the United States, and this percentage continues to rise.[3] Despite these advancements, female physicians still face financial disadvantages, including higher disability insurance premiums, which may impact their financial security and career longevity; and

Whereas, factors such as individual health histories, specific specialties, or career risks are more accurate predictors of disability risk than broad gender-based assumptions[2] and should be the primary focus of these insurance plans; and

Whereas, the issue of gender-based pricing in disability insurance for physicians must be viewed within the broader context of ongoing efforts to eliminate gender disparities in health care and the medical profession; and

Whereas, our American Medical Association has emphasized the importance of ensuring that disability insurance policies are robust and accessible for all physicians, including those on visas (H-330.869); and

Whereas, it is clear that gender-neutral disability insurance premiums are not only a matter of fairness but also a necessary step toward a more inclusive and supportive health care system. The elimination of gender-based pricing would be a significant move toward ensuring that all physicians—especially women—can pursue their careers with the same financial security as their male counterparts, free from the financial burdens created by outdated assumptions and systemic biases; therefore be it

RESOLVED, that our American Medical supports gender-neutral disability insurance premiums for physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/18/25

REFERENCES

1. https://www.whitecoatinvestor.com/why-disability-insurance-is-more-expensive-for-women/
2. https://www.whitecoatinvestor.com/what-you-need-to-know-about-disability-insurance/
3. https://publications.aap.org/pediatrics/article/148/Supplement%202/e2021051440C/183791/State-of-Women-in-Medicine-History-Challenges-and?autologincheck=redirected
4. https://www.mass.gov/info-details/disability-insurance#:~:text=What%20factors%20cannot%20determine%20my,or%20the%20person%20being%20pregnant
5. Click or tap here to enter text.

RELEVANT AMA POLICY

Updating Physician Job Description for Disability Insurance H-330.869

1. Our American Medical Association supports efforts to develop specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs.

2. Our AMA supports removing the barriers to obtaining and claiming disability insurance for physicians on visas.