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REPORT 14 OF THE (I-26)

Patient Options to Restrict Secondary Use of Their Healthcare Data

EXECUTIVE SUMMARY

At the American Medical Association's (AMA's) 2025 Interim Meeting, Resolution 004-I-25 was introduced, "Patient Options to Restrict Secondary Use of Their Healthcare Data," which focused on AMA's support for healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, and retroactively withdraw their data from de-identified data sets. The resolution was referred.

The "Health Insurance Portability and Accountability Act (HIPAA) of 1996" provides patients with limited ability to restrict secondary uses of their healthcare data, but the extent of control depends on the type of data, who holds it, and the purpose of the use. HIPAA generally prohibits covered entities (CEs) and business associates (BAs) from using or disclosing protected health information (PHI) unless authorized by the patient, except for certain specific instances and scenarios.

For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required or permitted scenarios, HIPAA requires a written, specific, patient authorization. Many legal scholars regard disclosure for purposes of TPO as the main channel through which secondary use of patient data occurs without any additional patient consent. An additional broad catalyst of secondary use is what is referred to as de-identification of health data. Once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. De-identified data can be used, sold, published, or transferred to non-HIPAA-covered recipients without patient authorization, including for AI model training.

The AMA has longstanding policy supporting the supremacy of patient privacy rights and the importance of AI model development that prioritizes data privacy as well as disclosures about how individuals' data is used or reused. AMA policy also includes a flat prohibition on re-identifying data for secondary AI use. It sets a hard line against exactly the kind of "de-identify, then re-identify" pattern that makes secondary use of health data risky, and the AMA also calls out de-identification itself as an unreliable basis for permitting secondary AI use.

The Board of Trustees recognizes the challenges posed by unauthorized secondary uses of patient data. There is real tension between patients' privacy rights and the growing secondary use of health data, particularly in the context of AI development, deployment, and use. Stakeholders in the healthcare community continue to seek larger datasets to develop and train AI models. AMA's advocacy efforts are ongoing and will continue to emphasize the importance of strengthening patient privacy protections and modernizing regulatory frameworks to address AI-driven data use. This includes continuing to advocate for stronger privacy safeguards, greater transparency, and regulatory mechanisms that provide patients with more meaningful control over the secondary uses of their health information.

The Board of Trustees recommends that the AMA continue to support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including retroactive withdrawal of their data from de-identified data sets.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 14-I-26

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

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 004-I-25, “Patient Options to Restrict Secondary Use of Their Healthcare Data,” was referred. It asked the following:

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 to retroactively withdraw their data from de-identified data sets.

Testimony was limited, with the majority of online testimony in favor of referral for study. Delegates offered mixed views during in-person testimony, with the majority favoring non-adoption.

BACKGROUND

HIPAA Provisions for Patients to Restrict Secondary Use of Their Healthcare Data

Secondary use of healthcare data generally means using patients’ health data for purposes other than direct patient care. These purposes include clinical research, public health activities, marketing, augmented intelligence (AI) model development, and insurance operations. The “Health Insurance Portability and Accountability Act (HIPAA) of 1996”¹ provides patients with limited ability to restrict secondary uses of their healthcare data, but the extent of control depends on the type of data, who holds it, and the purpose of the use.

HIPAA applies to covered entities (CEs), which consist of medical providers, health plans, and healthcare clearinghouses. Patient information is generally collected by a medical provider or health plan, at which point that information is deemed protected health information (PHI) under HIPAA and subject to its privacy and security protections. These provider and health plan CEs, in order to facilitate the processing of their PHI for claims payment, business analytics, and other purposes, generally will contract with one or more entities that perform these services; HIPAA terms these entities “business associates” (BAs). The disclosure of PHI from the CE to the BA is strictly regulated and may only be done according to the terms of a BA agreement.

HIPAA generally prohibits a CE or BA from using or disclosing PHI unless authorized by the patient, except for two instances where disclosure is required² and six scenarios where disclosure is permitted,³ but not required. For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required/permitted scenarios,⁴ HIPAA requires a written, specific, patient authorization. Most marketing communications and instances of sale of

PHI receive heightened patient authorization requirements as exemplars of secondary uses of data, as the patient likely did not anticipate at the time of disclosing their information and did not meaningfully provide consent.

The principal carve-out from the general prohibition on use and disclosure of PHI is when that is done for purposes of TPO, which many legal scholars see as the main channel through which secondary use of patient data occurs without any additional patient consent. Because the definition of healthcare operations is broadly interpreted, and not confined to a specific clinical encounter, the “operations” purpose can be used as a basis to authorize a wide range of secondary uses that do not require a fresh authorization for each use.

Physicians and other providers must allow patients to request restrictions on additional sharing of their data,⁵ although providers are not always required to agree to patients’ wishes.⁶ One important exception⁷ is that providers generally must honor a request not to disclose information to a health plan when the patient paid out of pocket in full for that service and no law requires the disclosure.

Fundamental to TPO use and disclosures of PHI, is the “minimum necessary” standard,⁸ which states that CEs must make reasonable efforts to limit use, disclosure, and requests for PHI to the minimum data necessary to accomplish the intended purpose. Minimum necessary requirements regulate how much data is disclosed by a CE for a given purpose. There are several significant built-in exceptions exempt from minimum necessary requirements, such as disclosures for treatment purposes, to the individual, or to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR).

42 Code of Federal Regulations (CFR) Part 2 (42 CFR Part 2)

It is also important to note that 42 CFR Part 2 was revised in 2024,⁹ altering privacy protections for patients seeking substance use disorder (SUD) treatment by aligning them more closely with HIPAA rules. The updated regulations expand certain patient rights and enforcement by adopting HIPAA’s penalty structure, requiring healthcare providers to follow standard breach notification rules, and granting a patient the right to request an accounting of disclosures. However, the changes have elements that can weaken confidentiality through easier record sharing after a single, general patient consent and put patients at risk of discrimination and stigma in healthcare or employment without providing strong enough parallel anti-discrimination protections. Written patient consent is generally required before a provider can use or disclose SUD treatment records. Under 42 CFR Part 2, patients can provide a single, general consent for all future uses and disclosures for treatment, payment, and healthcare operations. Another safeguard is the prohibition on the use of SUD records or testimony in any criminal, civil, administrative, or legislative proceedings against the patient without their consent or a specific court order.

Information Blocking Rule Provisions for Patients to Restrict Secondary Use of Their Healthcare Data

Uses and disclosures of PHI were further regulated at the federal level with development of Information Blocking Rule (IBR) regulations, promulgated in 2020 pursuant to the “21st Century Cures Act.” The IBR regulations govern electronic health information (EHI) and align with HIPAA, but require that under the six scenarios¹⁰ where disclosure is permitted, such disclosures are now required, unless they fit into one of the exceptions stated in the IBR regulations: “[I]f an actor is permitted to provide access, exchange, or use of EHI under the HIPAA Privacy Rule (or any other law), then the information blocking provision would require that the actor provide that

access, exchange, or use of EHI so long as the actor is not prohibited by law from doing so (assuming that no exception is available to the actor).”¹¹

How does this IBR provision affect a patient’s right to restrict secondary use of their data?

The IBR’s Privacy Exception¹² allows actors to protect patient privacy by respecting preconditions under federal or state laws or formal, documented individual consent choices. Because HIPAA gives individuals the right to request privacy protection for PHI¹³ the IBR regulations do not disturb those protections. The specific IBR exception that applies and, as referenced in the above-quoted excerpt from the “21st Century Cures Act,” is an individual’s request not to share EHI, which is governed by 45 CFR §171.202¹⁴ specifically, sub-exception (e).

The broadest catalyst of secondary use is de-identification of health data. Once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. De-identified data can be used, sold, published, or transferred to non-HIPAA-covered recipients without patient authorization. OCR guidance states that removing personal identifiers from health information mitigates any privacy risks to individuals and supports the secondary use of data for many additional purposes, including for AI model training, which was not envisioned when the HIPAA regulations were finalized nearly 25 years ago.

HIPAA BAs can also play a role in secondary uses of data. Like CEs, BAs are required to maintain the HIPAA Security Rule’s administrative, physical, and technical safeguards, and can only use or disclose PHI as necessary to perform the contracted services for the CE, or as required by law. The Security Rule requires that BAs and CEs protect against any reasonably anticipated uses or disclosures of PHI that are not permitted or required under the Privacy Rule, and BAs must provide CEs with written assurances that they will safeguard HIPAA-covered information and handle PHI appropriately.

The HIPAA Privacy Rule provides specifics on whether the secondary use of data is permissible while the HIPAA Security Rule stipulates the infrastructure potency needed to protect the data and allows secondary data uses to occur in a safe and limited fashion.

AMA POLICY

The AMA has longstanding policy supporting the supremacy of patient privacy rights and the importance of AI model development that prioritizes data privacy as well as disclosures about how individuals’ data is used or reused. The Board notes the following policy excerpts are particularly relevant to this discussion:

[Policy 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

- 1 confidentiality, and then only when such invasions or breaches are subject to
- 2 stringent safeguards enforced by appropriate standards of accountability;
- 3 c. that patients' privacy should be honored in the context of gathering and
- 4 disclosing information for clinical research and quality improvement activities,
- 5 and that any necessary departures from the preferred practices of obtaining
- 6 patients' informed consent and of de-identifying all data be strictly controlled;
- 7 d. that any information disclosed should be limited to that information, portion of
- 8 the medical record, or abstract necessary to fulfill the immediate and specific
- 9 purpose of disclosure; and
- 10 e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 11 be the minimal standard for protecting clinician-patient privilege, regardless of
- 12 where care is received

13 . . .

14

- 15 4. Whenever possible, medical records should be de-identified for purposes of use in connection
- 16 with utilization review, panel credentialing, quality assurance, and peer review.
- 17 5. The fundamental values and duties that guide the safekeeping of medical information should
- 18 remain constant in this era of computerization. Whether they are in computerized or paper
- 19 form, it is critical that medical information be accurate, secure, and free from unauthorized
- 20 access and improper use . . .

21

22 Policy H-480.931, "Assessing the Intersection Between AI and Health Care"

23

24 1. General Governance

- 25 a. Health care AI must be designed, developed, and deployed in a manner which
- 26 is ethical, equitable, responsible, accurate, transparent, and evidence-based.
- 27 b. Use of AI in health care delivery requires clear national governance policies to
- 28 regulate its adoption and utilization, ensuring patient safety, and mitigating
- 29 inequities. Development of national governance policies should include
- 30 interdepartmental and interagency collaboration . . .

31 ...

32

33 6. Data Privacy and Augmented Intelligence

- 34 a. Entity Responsibility:
- 35 i. Entities, e.g., AI developers, should make information available
- 36 about the intended use of generative AI in health care and identify
- 37 the purpose of its use. Individuals should know how their data will
- 38 be used or reused, and the potential risks and benefits.
- 39 ii. Individuals should have the right to opt-out, update, or request
- 40 deletion of their data from generative AI tools. These rights should
- 41 encompass AI training data and disclosure to other users of the
- 42 tool.
- 43 iii. Generative AI tools should not reverse engineer, reconstruct, or
- 44 reidentify an individual's originally identifiable data or use
- 45 identifiable data for nonpermitted uses, e.g., when data are
- 46 permitted to conduct quality and safety evaluations. Preventive
- 47 measures should include both legal frameworks and data model
- 48 protections, e.g., secure enclaves, federated learning, and
- 49 differential privacy . . .

[Policy H-315.958, “Ensuring Privacy in Retail Health Care Settings”](#)

...

6. Our AMA supports the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent . . .

AMA policy is explicit that a patient’s right to control secondary use extends to the training set itself, not just to the disclosure of a single record. Under the “Entity Responsibility” provisions, entities developing generative AI must make clear what the intended use of an individual’s data is, and “these rights should encompass AI training data and disclosure to other users of the tool.” The policy is explicit that the rights to opt-out, update, or delete one’s data grant patients the ability to reach back into the model’s training structures, not just to a single disclosure event. This distinction is critical and more granular than the original HIPAA considerations since HIPAA’s access and accounting-of-disclosures rights were not written with model training in mind.

AMA policy also includes a flat prohibition on re-identifying data for secondary AI use. It sets a hard line against exactly the kind of “de-identify, then re-identify” pattern that makes secondary use of health data risky: generative AI tools should not reverse-engineer, reconstruct, or re-identify an individual’s originally identifiable data, nor use identifiable data for purposes beyond what was permitted. The policy also directs that this be enforced through both legal agreements and technical controls, including by naming specific architecture-level safeguards that should back up the legal restriction, rather than relying solely on contractual promises alone.

AMA policy also calls out de-identification itself as an unreliable basis for permitting secondary AI use. The policy posits that many tools marketed as “HIPAA-compliant” rely on outdated notions of de-identification by simply stripping personal identifiers, and warns that with today’s computing power, such data can easily be re-identified. HIPAA’s own framework logic (if you “de-identify data, it is no longer PHI”) has served as an entry point for unrestricted secondary use of health data. The AMA’s position is that historical “de-identification” with the current reality of “re-identification” as it currently stands for AI training purposes, creates tremendous risk for patient privacy. Consequently, privacy needs to be designed into technology products from their inception rather than retrofitted through identifier removal after development concludes.

In addition, AMA policy emphasizes the importance of the data minimization requirements and how entities should only collect the minimum data needed for a stated purpose. Ultimately, this functions as an upstream restriction on secondary use, since data that was never collected in the first place cannot later be repurposed into a training set.

These policies provide the basis for AMA’s ongoing regulatory and legislative advocacy efforts on patient privacy, including reforms and updates to HIPAA regulations, and development of robust AI governance policies.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 004-I-25 and recognizes the challenges posed by unauthorized secondary uses of patient data. A 2022 AMA survey¹⁵ found that while 92 percent of people believe that privacy of their health data is a right, most are unclear about the rules relevant to their privacy. The AMA is concerned that health data are increasingly vulnerable and has called for regulations for an individual’s right to control, access, and delete personal data collected about them. As discussed above, patients have historical ways to restrict

secondary uses. Under HIPAA, patients may request restrictions on how providers and health plans use or disclose their PHI. Although providers must allow patients to make such requests, they are not always required to agree.¹⁶ The minimum necessary standard provides that CEs must make reasonable efforts to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

However, once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. Typical (and innumerable) de-identified data use cases are using data to train AI models. Specifically, discrete data fields of structured patient data and unstructured data from clinical notes and discharge summaries are “de-identified” by EHRs and healthcare institutions and used to train AI, which can, in turn, use the data to “re-identify” the patient. Furthermore, there is concern that the original unstructured clinical narratives can never feasibly be “de-identified” because the descriptors can sufficiently describe a singular patient without the name, date of birth, gender or other historically considered identifiable variables. De-identification is a misnomer, since de-identified data is not equivalent to anonymous data.

Moreover, AMA Privacy Principles¹⁷ underscore rights that an individual should possess. Our principles highlight that individuals have the right to know exactly what personal data an entity is accessing, using, disclosing, and processing—and for what purpose—at or before the point of collection. Individuals also have the right to control how entities access, use, process, and disclose their data, including secondary (and beyond) uses.

AMA has regulatory and legislative advocacy outreach on these topics and continues to look for opportunities to address the use and possible misuse of de-identified data as well as retroactively withdraw that data from AI training and other data sets. The Administration has thus far focused on and prioritized fostering AI innovation and adoption across sectors, rather than developing a robust AI governance model that preserves patient privacy and security. Accordingly, current governance does not include set provisions for retroactively removing de-identified data from training sets. As policymakers continue to navigate the rapidly evolving AI landscape, the AMA’s advocacy has centered on educating them about both the potential and limitations of AI, while promoting its responsible development, deployment, and use in healthcare through the lens of AMA policy.

Legislative Action

Discussions on updating HIPAA privacy and security laws are continuing in Congress. One of the most prominent bills is Senator Bill Cassidy’s, MD (R-LA) “[Health Information Privacy Reform Act](#)” (HIPRA, S. 3097). This bill was introduced in November 2025 and addresses secondary use of patient data primarily by closing gaps in HIPAA’s existing framework rather than creating an entirely new secondary-use framework. The bill was considered by the Senate Health, Education, Labor, and Pensions (HELP) Committee and was voted out unanimously. AMA advocacy staff has been working with the HELP Committee to provide technical assistance and insights regarding these issues, and have seen positive changes in the legislation.

HIPRA extends HIPAA-style limits to non-HIPAA entities by defining a new category of “regulated entity” that covers essentially any organization that determines the purpose and means of processing “applicable health information.” This definition would be broader than existing protections, and HHS would be directed to extend HIPAA Privacy, Security Rule-style protections to this data, closing the gap for wearables, wellness apps, and direct-to-consumer health platforms which currently face no federal use restrictions once they acquire health data (although individuals may have some privacy protections from the Federal Trade Commission (FTC) Act,¹⁸ the FTC

1 Health Breach Notification Rule,¹⁹ and an increasing number of state health privacy laws). The bill
2 also restricts secondary use through HIPAA's right of access. Currently, once a patient directs their
3 PHI to a third party via HIPAA's right of access, HIPAA no longer governs that data. HIPRA
4 would require the patient to state the purpose of the disclosure before it happens, and would let the
5 disclosing entity bind the third-party recipient to the patient's stated use restrictions, essentially
6 making the patient's designated purpose(s) for the disclosure of the data part of the data exchange.

7
8 HIPRA also targets AI training specifically, by directing HHS to issue guidance on applying the
9 "minimum necessary" standard to AI/Machine Learning development, address when "limited data
10 sets" are appropriate for that purpose and establish new national de-identification standards. These
11 new standards are a direct response to AI training, being a secondary data use that strips personal
12 identifiers from individuals' data. This scenario currently surpasses the legal landscape and thus
13 needs to be considered and folded into regulation as this area continues to rapidly expand.

14
15 In addition, HIPRA requires entities to tell patients once their data exits HIPAA protections, when
16 their data is accessed by a third party and is no longer HIPAA-protected, and that their data may be
17 redisclosed

18 19 *State Action*

20
21 Many states have used changes to their privacy laws to address de-identified data issues and
22 restrictions on its use.

23
24 The California "Consumer Privacy Act" (CCPA) and the California "Privacy Rights Act" (CPRA)
25 provide the most developed state framework and give consumers a right to delete their personal
26 information, but exempts de-identified information from that right entirely if it meets a three-part
27 test. The test requires that an entity: (1) implement reasonable technical and business-process
28 safeguards to prevent re-identification of the data; (2) publicly commit to maintaining the data in a
29 de-identified form and refrain from attempting to re-identify it; and (3) contractually require any
30 downstream recipients to uphold the same commitments. If the entity meets those thresholds, an
31 individual's deletion request simply does not reach that dataset because the data has been deemed
32 sufficiently de-identified. CCPA/CPRA also has a research-specific exception, allowing an entity
33 to retain data despite a deletion request where deleting it would seriously impair research and the
34 consumer has already provided informed consent, which does not allow an individual to
35 retroactively change their mind about sharing their data.

36 37 **CONCLUSION**

38
39 There is real tension between patients' privacy rights and the growing secondary use of health data,
40 particularly in the context of AI development, deployment, and use. AMA advocates for patients
41 who seek to safeguard their privacy, while recognizing the imbalance of influence between patients
42 and health systems who encourage patients to enter PHI into their portals with the potential to
43 monetize that individual's data. Under HIPAA, health data generally may not be used or disclosed
44 without patient authorization, except for TPO, and a set of well-defined purposes. While HIPAA
45 provides certain mechanisms for patients to restrict data sharing, its broad interpretation of "health
46 care operations" has enabled substantial secondary uses of patient information to proliferate
47 without additional consent mechanisms.

48
49 Stakeholders in the healthcare community continue to seek larger datasets to develop and train AI
50 models. Although HIPAA's de-identification standards were designed to mitigate privacy risks,
51 technology advances in computing power and data analytics have raised new concerns about re-

identification and the adequacy of decades-old regulatory assumptions and standards. The AMA's policy positions reflect these concerns by emphasizing that patients should understand how their data are used, reused, and incorporated into AI training datasets, and by asserting rights to opt out, update, or request deletion of their data, including within AI training models.

The AMA views de-identification alone as an insufficient safeguard for modern AI applications. AMA policy calls for both legal and technical protections against re-identification, including privacy-preserving approaches such as secure enclaves, federated learning, and differential privacy. It also emphasizes data minimization, transparency, and privacy-by-design principles that limit secondary uses before data are collected rather than attempting to mitigate risks afterward.

AMA's advocacy efforts are ongoing and will continue to emphasize the importance of strengthening patient privacy protections and modernizing regulatory frameworks to address AI-driven data use. This includes educating policymakers about both the opportunities and limitations of AI and promoting governance structures that balance innovation with patient trust and autonomy. There are significant gaps in the rights that individuals possess to limit secondary uses of their data. Moreover, considerable discrepancies remain once health information is de-identified, and what de-identification really means in the setting of natural language processing of unstructured narratives. As AI development increasingly relies on large-scale health datasets, the AMA will continue to advocate for stronger privacy safeguards, greater transparency, and regulatory mechanisms that provide patients with more meaningful control over the secondary uses of their health information.

RECOMMENDATION

The Board of Trustees recommends that Resolution 004-I-25 be adopted as amended by addition and deletion and the remainder of the report be filed.

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

Fiscal Note: Minimal.

REFERENCES

¹ See <https://www.hhs.gov/hipaa/for-professionals/index.html>.

² A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.). [45 C.F.R. §164.502\(a\)\(2\)](#).

³ A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.¹⁸ Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. [45 C.F.R. §164.502\(a\)\(1\)](#), *supra* at note 1.

⁴ See [45 C.F.R. §164.502\(a\)](#) *supra* at notes 2, and 3.

⁵ See [45 C.F.R. §164.502\(a\)\(2\)](#) *supra* at note 2.

⁶ See [45 C.F.R. §164.522\(a\)\(2\)](#) *supra* at note 3.

⁷ See [45 CFR 164.522\(a\)\(1\)\(B\)\(vi\)](#), and [45 C.F.R. §164.502\(a\)\(1\)](#), *supra* at note 3.

⁸ The minimum necessary standard is defined under the HIPAA Privacy Rule in federal regulations [45 CFR §164.502\(b\)](#), which sets the core standard requiring reasonable limits on any use, disclosure, or request for PHI to accomplish its intended purpose, and [45 CFR §164.514\(d\)](#), which details the operational requirements, policies, procedures, and criteria for determining what constitutes the minimum necessary for routine and non-routine disclosures. These rules require covered entities and business associates to make reasonable efforts to limit disclosure of PHI to the specific amount needed.

⁹ See <https://www.federalregister.gov/documents/2024/02/16/2024-02544/confidentiality-of-substance-use-disorder-sud-patient-records>.

¹⁰ See [45 C.F.R. §164.502\(a\)\(2\)](#) *supra* at note 2.

¹¹ See [84 FR 25642, 25812, May, 2020](#).

¹² See [45 CFR §171.202 Privacy exception—When will an actor's practice of not fulfilling a request to access, exchange, or use electronic health information in order to protect an individual's privacy not be considered information blocking?](#)

¹³ See [45 C.F.R. §164.522\(a\)\(2\)](#), *supra* at note 3.

¹⁴ *Ibid.*, see sub-exception (e).

¹⁵ See <https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf>.

¹⁶ See [45 C.F.R. §164.522\(a\)\(1\)\(ii\)](#), *supra* at note 3.

¹⁷ See <https://www.ama-assn.org/system/files/2020-05/privacy-principles.pdf>.

¹⁸ See <https://www.ftc.gov/legal-library/browse/statutes/federal-trade-commission-act>.

¹⁹ See <https://www.ftc.gov/legal-library/browse/rules/health-breach-notification-rule>.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-I-26

Subject: Gender-Based Pay Equity in Medicine

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 American Medical Association (AMA) Interim Meeting, the House of Delegates (HOD) adopted Policy D-385.939 “Report on Gender-Based Pay Equity in Medicine.” The policy directs the AMA “to study and report at I-26 the current pay structures and existing gender-based disparities in physician pay.” The policy further calls on the AMA to “propose data-driven guidance to end gender-based pay disparities and create strategies to achieve transparency and equitable compensation across medical practice settings.”

This report describes current physician compensation structures, reviews evidence on existing gender-based compensation disparities, identifies factors that may contribute to those disparities, and summarizes relevant AMA policy. The report also outlines evidence-informed approaches to addressing persistent inequities in physician compensation.

BACKGROUND

Current compensation structures

Physician compensation in the United States generally consists of three primary components: base salary, productivity-based compensation, and incentive bonuses.¹ While compensation models vary across practice settings and specialties, organizations use a combination of these elements to reward clinical work, support organizational goals, and incentivize high-quality patient care.²

The AMA Physician Practice Benchmark Survey provides a comprehensive snapshot of physician practice arrangements, characteristics, and trends across the United States. A recent AMA analysis of Benchmark Survey data found that 70.5 percent of physicians receive a salary, making it the most common mode of compensation. The analysis also found that 55 percent of physicians receive some form of productivity-based compensation, and 39 percent receive some form of bonus compensation.¹ Bonus compensation may be tied to quality performance measures, patient satisfaction scores, research productivity, teaching responsibilities, or leadership contributions.³ Blended compensation models are also becoming more common: in 2024, 60.8 percent of physicians received compensation from more than one of these three categories, up from 51 percent in 2014.¹

On average, compensation structures also differ between male and female physicians, with male physicians receiving a larger share of their income from productivity-based compensation and a smaller share from salary than female physicians. This pattern suggests that male physicians may have greater earning potential under current compensation models because more of their income is tied to variable, productivity-based pay.¹

Existing gender-based compensation disparities

Gender-based compensation disparities are well documented across medical specialties and practice settings, with female physicians earning less than their male counterparts.⁴ The Doximity 2025 Physician Compensation Report found a 26 percent physician gender pay gap in 2024. Even after adjusting for specialty, geographic location, and years of experience, female physicians earned an average of \$120,917 less annually than their male counterparts.⁵ Over a 40-year career, a disparity of this magnitude could translate into approximately \$2 million less in gross income for a female physician.⁶

These disparities are driven in part by both the unequal distribution of male and female physicians across specialties and differences in earnings between specialties. Female physicians are disproportionately represented in lower-compensated specialties, including pediatrics, family medicine, endocrinology, and obstetrics and gynecology. By contrast, male physicians remain overrepresented in higher-paying, often procedural specialties such as orthopedic surgery, diagnostic radiology, critical care medicine, and interventional cardiology.⁷

Differences in physician productivity may also contribute to gender-based pay gaps, particularly in payment models that tie compensation to patient volume and other quantifiable outputs. One study found that female primary care physicians spend about six percent more time with patients per visit than male primary care physicians.⁸ Proposed explanations for this finding include that female physicians may provide more detailed explanations to patients, take more thorough patient histories, or offer more counseling during visits. Evidence also suggests that female physicians spend approximately 20 percent more time managing electronic health record portal messages than male physicians, in part because they receive 24 percent more staff messages and 26 percent more patient messages.⁹ Taken together, these differences may affect compensation in systems that reward visit volume more heavily than time-intensive patient care.

Although measurable factors may explain a substantial portion of the physician gender pay gap, compensation disparities persist even after adjusting for specialty, practice setting, productivity, and other observable variables. This persistence suggests that less easily measured factors also contribute to inequitable compensation.

One such factor is the disproportionate share of childcare and other caregiving responsibilities assumed by female physicians. In one study, marriage and children were associated with an earnings penalty for female physicians, who worked seven percent fewer hours when married without children and 18 percent fewer hours with children than male physicians.¹⁰ This difference may reflect greater caregiving demands and household responsibilities.

Differences in salary negotiation may also contribute to compensation disparities. Male physicians are more likely to negotiate for higher salaries.¹¹ By contrast, female physicians may be less likely to negotiate pay because they may face negative consequences for doing so and may be less likely to receive raises than their male counterparts when they do.¹²

Existing AMA Policy

These findings underscore the need for structural and policy interventions to promote equitable physician compensation. The AMA has established a robust policy framework addressing gender-based pay equity. Your Board identifies three policies as particularly relevant to persistent gender-based compensation inequities and to the AMA's commitment to advancing pay equity.

Policy H-65.961, “Principles for Advancing Gender Equity in Medicine,” affirms the AMA’s commitment to gender equity in medicine and identifies a variety of evidence-based approaches to addressing gender-based pay disparities, including salary transparency and compensation audits, among many others.

Policy D-65.989, “Advancing Gender Equity in Medicine,” supports advocacy for practice policies that promote compensation transparency, objective pay structures, training to increase awareness of potential gender bias in compensation systems, and the development of equitable compensation models. The policy also emphasizes collaboration with interested parties in advancing this work.

Policy D-65.983, “Gender Equity and Female Physician Work Patterns During the Pandemic,” supports research on data related to female physicians’ work patterns and employment outcomes, including potential inequities related to terminations, furloughs, and other gender-based differences observed during the pandemic.

DISCUSSION

Addressing physician gender-based pay disparities requires multifaceted, evidence-based interventions that target the structural drivers of compensation inequity. Although outcomes data remain limited, one of the most consistently recommended approaches is the implementation of transparent compensation systems that clearly delineate salary ranges, productivity benchmarks, bonus criteria, and additional compensation for leadership, administrative, and academic responsibilities.¹³⁻¹⁵ By reducing reliance on discretionary decision-making, transparent compensation structures can help limit unwarranted variation and facilitate the identification of unexplained salary differences. For example, an academic medical system reported that applying a structured compensation model incorporating multiple relevant factors resulted in gender pay equity.^{16,17}

Routine salary audits, or pay equity audits, are similarly important.^{13,18} These audits assess physician compensation using standardized methods that adjust for relevant factors, including specialty, clinical full-time equivalent status, years of experience, academic rank, productivity, leadership responsibilities, and geographic location. When conducted regularly, salary audits enable organizations to identify unexplained disparities, implement timely salary adjustments, and monitor the impact of compensation policies over time. One salary audit intervention among academic physicians resulted in salary adjustments that raised female salary as a percent of male salary from 89.4% pre-intervention to 93.5% post-intervention.¹⁹

Further, if female physicians are disadvantaged by productivity-based payment models, as discussed above, reforming physician compensation models so that they better account for value-based care, rather than primarily rewarding clinical volume, may promote greater equity. Traditional productivity-based models largely reward procedural intensity and patient volume, while undervaluing activities that are central to high-quality care, such as patient education, shared decision-making, interdisciplinary collaboration, teaching, and mentorship. Broadening compensation frameworks to recognize these contributions may reduce unintended biases associated with volume-driven reimbursement and support a more comprehensive evaluation of physician performance. Supporting this strategy, one study found that female physicians achieved similar or better quality outcomes and earned more than their male counterparts under a value-based payment model.²⁰

Overall, these approaches highlight that reducing gender-based pay disparities requires coordinated structural reform. As the AMA policies outlined above demonstrate, the AMA has already established a strong policy basis for evidence-informed strategies to improve compensation transparency, promote objective and gender-neutral pay structures, support regular review of compensation practices, and address bias through training, pay audits, and other corrective mechanisms. Existing AMA policy therefore not only reflects the AMA's commitment to pay equity but also provides a strong foundation for the reforms needed to address persistent gender-based compensation inequities.

Additional AMA resources on this topic are available on the AMA's [Advancing Gender Equity in Medicine: Resources for Physicians](#) webpage, which serves as a central repository of relevant policy and supporting materials.

RECOMMENDATIONS

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

1. That our American Medical Association encourage continued study of evidence-based interventions to promote gender pay equity for physicians. (New HOD Policy)
2. That AMA Policy D-65.989, "Advancing Gender Equity in Medicine," and AMA Policy H-65.961, "Principles for Advancing Gender Equity in Medicine," be reaffirmed. (Reaffirm HOD Policy)
3. That AMA Policy D-385.939, "Report on Gender-Based Pay Equity in Medicine," be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

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RELEVANT AMA POLICY

H-65.961 Principles for Advancing Gender Equity in Medicine

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

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.

Gender Equity and Female Physician Work Patterns During the Pandemic D-65.983

1. Our American Medical Association will advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality.
2. Our AMA will collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 18-I-26

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

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD), adopted Policy D-65.968, “Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients,” which directs the AMA as follows:

Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant collaborators (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)

Online testimony was in near unanimous support. The minimal in-person testimony was in unanimous support of the report as amended.

BACKGROUND

The usability of Electronic Health Records (EHRs) for transgender and gender diverse patients has taken on a new importance in the current political landscape given concerns about protecting individuals' privacy and maintaining patient agency over one's own data. Several initiatives are underway across the healthcare community to provide greater support for sharing sensitive health information and to ensure that data is protected from nefarious use. The AMA is collaborating across the sector to ensure that physicians and other providers can build trust, respect patient preferences when sharing data, and implement privacy protections for that data.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996¹ is the cornerstone of patient privacy. HIPAA generally prohibits a covered entity and their business associates from using or disclosing protected health information (PHI) unless authorized by the patient, except for two instances where disclosure is required² and six scenarios where disclosure is permitted,³ but not required. For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required/permitted scenarios listed above, HIPAA requires a written, specific, patient authorization.

Under HIPAA, patients also have the right to request restrictions on sharing their PHI. For example, a patient can ask a covered entity not to disclose certain PHI to a health plan for a service the patient paid for out of pocket, in full. In principle, this means a patient can keep a self-pay gender-affirming care visit out of their health records that are shared with an insurer. Patients also have the right to request confidential communications to protect their privacy—a patient can ask

that communications from a provider or plan be sent to an alternate address or by an alternate method. Patients have to affirmatively invoke these rights, and a covered entity must accommodate reasonable requests.

The issue of subpoenas and release of information for transgender and gender diverse patients under HIPAA is one of the more consequential issues impacting patient privacy. HIPAA does not compel disclosure even when PHI is subpoenaed; it permits it only after specific conditions are met. Physicians and other providers who receive a subpoena (rather than a court order) must obtain either satisfactory written assurance that the patient was given notice and an opportunity to object, or there is a “qualified protective order” limiting the scope of disclosure and requiring return or destruction of the records afterward, before disclosure is permitted. Without proof that the patient was notified of the subpoena and given a real chance to object or obtain a qualified protective order, HIPAA requires that the provider not disclose the records. Most of the current, highest-profile clashes over transgender patients’ medical record subpoenas concern subpoenas without a judge’s signature, which is a substantial step-down from a judge-issued subpoena, and holds less weight.

It is crucial to emphasize that HIPAA sets a minimum level of privacy protections, and states remain free to add stricter protections than the HIPAA privacy rules. Eighteen states and DC currently have shield laws offering protections for those providing and receiving gender-affirming care. This overlay has produced real legal friction where a provider is simultaneously subject to a federal subpoena and resides in a state with a stricter state confidentiality statute. Such a scenario creates a compliance dilemma over conflicting state and federal rules.

The Department of Health and Human Services (HHS) Office of the National Coordinator for Health IT’s (ONC’s)⁴ work on EHRs and data sharing intersects with patient privacy concerns. ONC has finalized rules that require EHR technology to be capable of tagging and restricting sensitive data, and rules that protect physicians and other providers who choose to honor a patient’s request to withhold part of their record. However, ONC has not finalized any rule that requires the actual segmentation of sensitive health data. Such a step would allow patients and providers to maintain granular privacy controls over sensitive health data within their health records. It would compartmentalize specific parts of an individual’s medical record—such as gender status/identity, mental health diagnoses, substance abuse treatment, or genetic information—so that they require higher authorization to view or share. This would allow patients to control who can see their private medical data while complying with strict privacy laws such as HIPAA.

Our work on data segmentation issues led to the AMA co-founding and serving on the Governing Board of the not-for-profit Shift Collaborative⁵ to help address the gap between what patients want and what technology can offer. Shift is an independent health care task force of over 300 expert stakeholders that seeks to advance a health care ecosystem in which better technology for clinical data sharing increases trust among patients, physicians, providers, and caregivers, improving health quality and outcomes, as today’s health data systems often force patients to choose between care and privacy. Shift believes that patients should be able to share the information they want safely, securely, and on their own terms. Ensuring that individuals’ data sharing preferences are respected is a critical component of advancing safe, effective, and patient-centered value-based care and chronic disease management.

The feedback Shift has received is that patients want, and physicians and other providers need, more features that support granular segmentation. In the absence of reliable, standards-based segmentation capabilities and with the complexities of Institutional Review Board (IRB) practices still unresolved, physicians and other providers may over-share to avoid information-blocking

liability, under-share to mitigate privacy risk, or under-document information in patients' charts, thereby making the chart less reliable.

Shift takes the view that data segmentation and computable consent can only be achieved at scale through Fast Healthcare Interoperability Resources (FHIR), which is why Shift is focusing its efforts on updating FHIR standards and collaborating with key partners across the community. In recognition of the need for granular segmentation, Shift created an open, standards-based sandbox tool that includes a redacted record viewer that simulates what a patient record with redacted information might look like, based on dynamic patient consent preferences. It also supports workflow demonstrations using synthetic data in a mock EHR environment and will soon allow vendors to connect their products via FHIR application programming interfaces (APIs) to test and validate these workflows within their systems using Shift's synthetic data, use cases, and implementation guidance. To this end, Shift is drafting an implementation guide to assist technology partners with implementation.

With the creation of its sandbox, Shift's work is supporting the community's transition to FHIR. The future of data segmentation and computable consent is in FHIR, and Shift's sandbox is our community's best shot at quickly scaling these functionalities.

AMA POLICY

The AMA has longstanding policy supporting patient privacy and promoting the use of EHRs and other health technologies to support patients in their health journeys. The Board notes the following policies as particularly relevant to this discussion:

Policy 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 . . .

Policy D-478.972, “EHR Interoperability”

1. Our American Medical Association will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive-Based Payment System . . .

Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians”

- 1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status . . .

AMA policy provides clear advocacy priorities to protect patient information, improve health data exchange, and advance EHR innovation and usability.

DISCUSSION

The Board understands the growing concerns among patients, physicians, providers, and other interested parties that the indiscriminate sharing of health data may be used against them or lead to other irreversible, deleterious consequences. While improved transparency regarding data exchange and audit trails may be helpful, these interventions do not mitigate apprehension regarding data that have already been shared.

Concerns about indiscriminate access to and use of personal health data are higher among marginalized populations, including racial and sexual minorities, as well as individuals with housing insecurity and immigrant populations. In addition, concerns are higher among patients with reported lower trust in the health system and those who have experienced either lower quality or discriminatory care. Patients with such privacy concerns may withhold information from physicians or fail to seek appropriate treatment, which perpetuates disparities in care. These privacy concerns can permeate the healthcare delivery system and affect substantial parts of it. For example, the inability to control sharing of one’s data has been shown to further reinforce mistrust in the health ecosystem, which is associated with decreased likelihood to follow medical advice, receive recommended preventive care, fill prescriptions and keep follow-up appointments, as well as higher Emergency Department use, reduced continuity of care, and more advanced conditions when care is sought, resulting in poorer outcomes and overall higher costs of care. Addressing greater protections around personal health information and strengthening sharing policies is paramount.

The health IT vendor community has historically pushed back against granular data redaction since they have not been required to enable this functionality, and it could result in unintended downstream safety implications for patients. For these reasons, ONC’s efforts in this space to emphasize the necessity of data segmentation to vendors and the entire community are vital.

Back in 2011, ONC launched the Data Segmentation for Privacy (DS4P) Initiative⁶ as a pilot program, with a goal to demonstrate, through small pilot projects, that it is technically possible to share part of a medical record while withholding sensitive information, rather than the “share

everything or share nothing” default that most EHR systems used. This was proof-of-concept work that was later incorporated into actual Health IT Certification rules, resulting in the 2015 Edition Health IT certification criterion. The requirement was that software must be able to mark a portion of a health record as “restricted” using a specific technical labeling standard (Health Level Seven’s DS4P standard). This standard essentially labeled an individual’s health information as “sensitive,” and flagged it for stricter disclosure requirements before it could be shared.

With the 2015 Edition Health IT certification criterion, ONC simply finalized requirements that health IT software have the capability, without ever finalizing a rule requiring providers to actually use that capability in any particular way. Further work from ONC on API Consent Management capabilities was helpful in requiring certified software to support tools that let patients (or systems acting on their behalf) manage granular consent preferences when data moves through modern API-based data-sharing channels that power patient portals and other health apps.

ONC’s Information Blocking Rules also impact a physician or other regulated actor’s ability to share or withhold sharing of an individual’s granularly segmented health data. The exceptions that ONC has defined support physicians’ efforts to abide by patients’ wishes about sharing or restricting the sharing of sensitive data, although the community is still waiting for HHS enforcement of Information Blocking rules to fully materialize; therefore, many questions remain.

In December 2024 rulemaking, ONC’s Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability” (HTI-2 Rule)⁷ was finalized without a previously proposed provision to require data segmentation capabilities in certified health IT.

Without these ONC requirements in place, the work of the Shift Collaborative is indispensable in supporting our community’s efforts to make progress toward enabling greater data segmentation capabilities. The Shift Sandbox is a live, open source, publicly accessible test environment where health IT developers can see data segmentation actually functioning, where sensitive data is being tagged at the source, patients are able to set sharing preferences, those preferences are automatically enforced, and redaction of data and revocation of privileges work seamlessly with data sharing processes. The sandbox will be showcasing real-world use cases using FHIR and standards-based data segmentation, security labeling, and consent enforcement, meant to help clinicians, policymakers, developers, and implementers understand, test, and advance the vision of granular, patient-centered data sharing.

There are three clinical scenarios currently being tested—an older adult who wants his primary care team, but not third-party apps, to see his history of depression and opioid use disorder; or to adolescents who want to keep reproductive health and gender-identity information private from certain viewers of a shared patient portal. Once the segmentation and consent logic is proven, it can be applied to other use cases and directly support transgender and gender diverse patients and their needs related to privacy and sharing preferences.

CONCLUSION

The protection of sensitive health information for transgender and gender diverse patients represents both an urgent privacy imperative and a broader test of the healthcare system’s ability to maintain patient trust in an increasingly interconnected digital environment. While HIPAA establishes an essential baseline for safeguarding PHI, evolving legal, technological, and social challenges underscore the need for more robust and patient-centered approaches to data governance.

1 Current limitations of EHR systems, particularly the lack of widespread implementation of granular
2 data segmentation capabilities, continue to constrain patients' ability to exercise meaningful control
3 over how their information is shared and used. The evidence suggests that stronger privacy
4 protections are not only important for safeguarding individual autonomy but are also fundamental
5 to promoting access to care, fostering trust, and improving health outcomes.

6
7 The AMA's leadership role in initiatives such as the Shift Collaborative demonstrates a strong
8 commitment to advancing solutions that support both patient privacy and effective clinical care. By
9 providing practical tools, implementation guidance, and real-world testing environments, these
10 efforts are helping to accelerate the development of health IT systems capable of honoring patient
11 consent at a granular level. Continued collaboration among policymakers, physicians, other
12 providers, standards development organizations, vendors, and patient advocates will be essential to
13 achieving this vision.

14
15 Ultimately, the future of patient-centered data sharing depends on creating health information
16 systems that are both interoperable and trustworthy. Ensuring that individuals can safely share
17 health information on their own terms will strengthen confidence in the health care system,
18 improve continuity of care, and support better health outcomes for transgender and gender diverse
19 patients and other populations with heightened privacy concerns. The advancement of scalable data
20 segmentation and consent-management capabilities should remain a priority for the AMA and the
21 entire community as work continues to align technological innovation with fundamental principles
22 of privacy, autonomy, and equity.

23 24 RECOMMENDATIONS

25
26 The Board of Trustees recommends that Policy D-65.968 be amended by deletion as accomplished
27 by this report, and that the remainder of the report be filed:

28
29 Our AMA continue to support efforts by EHR vendors, health systems, and physician
30 practices, and work with relevant collaborators (e.g., the ASTP/ONC, LGBTQIA+
31 advocacy groups, and minors' privacy experts), to improve EHR usability for transgender
32 and gender-diverse patients, with attention to strong privacy protections, ~~and report back~~
33 ~~on this progress by I-26.~~ (Modify Current HOD Policy)

Fiscal Note: Minimal.

REFERENCES

¹ <https://www.hhs.gov/hipaa/for-professionals/index.html>.

² A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.). [45 C.F.R. §164.502\(a\)\(2\)](#).

³ A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. 45 C.F.R. §164.502(a)(1), viewable at the link in Note ii, *supra*.

⁴ <https://healthit.gov/>.

⁵ <https://www.shiftinterop.org/>.

⁶ https://healthit.gov/wp-content/uploads/2017/07/2015editionehrcertificationcriteriads4p_10615.pdf.

⁷ <https://healthit.gov/regulations/hti-rules/hti-2-final-rule/>.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 22-I-26

Subject: Clarifying Conscientious Objection

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the House of Delegates (HOD) adopted Policy [D-140.945](#), “Clarifying Conscientious Objection,” the first directive states:

Our American Medical Association will 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.

This report is submitted to the HOD in fulfillment of the above directive and provides background discussion and policy recommendations regarding physician exercise of conscience while protecting patients from harmful discrimination.

BACKGROUND

Increased legal and professional attention to physician exercise of conscientious objection, such as refraining from providing specific forms of care including but not limited to abortion services, gender affirming care, and family-planning methods, has generated concern that conscientious objection is being used by some physicians to target and discriminate against specific groups of patients.¹ While those critical of conscientious objection worry about discrimination and unequal access to care, proponents insist that it is necessary to uphold physician autonomy and protect physicians’ professional judgment at a time of increasing pressure on clinical decision-making from governmental and administrative forces.²

DISCUSSION

Concerns regarding conscientious objection as cover for discriminatory behavior are valid, though assessing and quantifying the prevalence of such instances remains difficult, especially regarding cases of refusal to provide care that do not meet legal standards of discrimination. Proving discrimination in a court of law can also be difficult because direct evidence is often rare. Additionally, without meeting a legal standard for discrimination, alleged instances where intent remains uncertain means that two parties can have vastly diverging views on whether or not an action was discriminatory.

Healthcare and social service providers must adhere to several federal civil rights laws and regulations enforced by the Office for Civil Rights. These include but are not limited to: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, Section 1557 of the Patient Protection and Affordable Care Act, Title II of the Americans with Disabilities Act, and Section

1908 and Section 1947 of the Public Health Service Act.³ Under federal law, it is illegal to treat certain protected classes of people differently or less favorably. The groups protected from discrimination include those based on race, religion, national origin, age, sex, sexual orientation, gender identity, pregnancy, family status, disability, veteran status, and genetic information.⁴ Alleged instances of physician conscientious objection as discriminatory can be particularly challenging because both the patient and the physician may claim that an action forcing them to not follow their beliefs or wishes is discriminatory if they belong to separate protected classes with opposing values, as is sometimes the case, for example, between some religious groups and sexual or gender minorities.

The AMA [*Code of Medical Ethics*](#) is clear that physicians have a right to exercise their conscience and act, or refrain from acting, in accordance with their beliefs but that such freedom is not without limits. Opinion 1.1.7, “Physician Exercise of Conscience,” states that physicians must provide care in cases of emergency, that their actions should not discriminate against or unduly burden individual patients or patient population, and they should provide a referral (or at minimum, information regarding access) for another physician or institution to provide any treatment refused the patient.⁵

While it has long been the ethical standard that “[p]hysicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive [or other] services that patients request”^{5,6}, this is not always the case. One national survey found that 11% of physicians believe that a physician does not have an obligation to refer a patient to another physician for a treatment they object to providing,⁷ while another national survey found that 19% of physicians strongly disagree and 25% moderately disagree that “[p]hysicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral.”⁸ These statistics validate concerns that physician conscientious objection to refuse care may lead to discrimination and unequal access to care for certain patient populations, such as those seeking gender affirming care or abortion services.^{9,10}

RELEVANT AMA POLICY

There exist several AMA policy provisions relevant to the issue of physician conscientious objection and related concerns regarding discrimination. [H-405.958](#) “Physician Right to Conscience” recognizes that physicians have differing beliefs and a right to exercise their conscience, and supports physicians conducting themselves in a civil and respectful manner. [H-65.951](#) “Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions” outlines several guidelines for organizations to establish anti-discrimination policies and an inclusive organizational culture. And [D-5.998](#) “Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era” further supports provisions protecting physician exercise of conscience of care “in accordance with accepted standards of medical care and medical ethics”, outlined in the *Code of Medical Ethics*. For a detailed analysis of relevant *Code* opinions, please refer to the corresponding CEJA report on Clarifying Conscientious Objection.

CONCLUSION

Physicians have a right to exercise their conscience. However, this right is not without limits and must be exercised in a manner that avoids harming patients and patient populations. Physicians have ethical obligations to respect patients as persons, to not impede timely care, and to uphold the primacy of patient welfare. While physicians may choose to refrain from providing care in

accordance with their conscience in certain circumstances, they must always do so in a professional and respectful manner. The conscientious refusal of care must never be done out of discrimination against a patient or patient population, nor should it give the appearance of such impropriety, as even the appearance of discrimination can be harmful to the trust that is foundational to the patient-physician relationship and the practice of medicine. Therefore, great care must be taken when physicians exercise conscience to ensure that patients are not negatively affected. This is especially true if a physician not only chooses to exercise conscience refusal but also to refuse to refer their patient to another qualified physician. While physicians may exercise their conscience, they should generally refer their patient to another physician or institution in accordance with *Code Opinion* 1.1.7; however, a physician may instead offer impartial guidance to the patient on how to inform themselves about access to a desired service in cases of “a deeply held, well-considered personal belief.”⁵ In such cases, though, the physician must still uphold their ethical obligations, including to the provision of timely care, as outlined in Opinion 1.1.6, “Quality Care,” and Opinion 1.1.3, “Patient Rights.”

RECOMMENDATIONS

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

1. Our AMA supports physicians’ right to exercise their conscience in the provision of care, but any conscientious refusal to provide care should be done in keeping with their ethical obligations to not invidiously discriminate against individual patients or patient populations. (New HOD Policy)
2. Our AMA encourages physicians to provide referral to patients in cases where the physician exercises their right to conscientious refusal, in order to reduce potential delays in care.
3. The first directive of D-140.945 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-26

Subject: Clarifications regarding Establishment and Nominations to AMA Committees

Presented by: Mary Ann Contogiannis, MD, Chair

Referred to: Reference Committee on Bylaws and Ethics

The House of Delegates (HOD) referred back the recommendations of CCB Report 2-I-25 which attempted to clarify the authority of the Board of Trustees (BOT) and the HOD with respect to the establishment of advisory committees as referenced in Bylaw [5.3](#), Board of Trustees Duties and Privileges. This was in response to an issue that arose at A-25 around a resolution calling for an Advisory Committee on Tribal Affairs, subsequently adopted as [Policy D-615.976](#). To implement this directive, the BOT established the Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs. While the outcome on this matter was positive, the root issue that generated referral of CCB's language related to whether it was the HOD or the BOT that had the authority to establish an advisory committee – not the merits of the advisory committee. The debate in both the reference committee and on the floor of the HOD centered on the ability of the HOD to establish an advisory committee, as the BOT had previously denied a similar request advanced in writing by the Medical Student Section (MSS).

Under our AMA Constitution and Bylaws, [CCB](#) issues bylaw language for HOD action, and [CEJA](#) interprets the Bylaws. At A-25, the resolution authors and supporting delegations approached CEJA for a bylaw interpretation, and CEJA opined that based on existing bylaw language and historical precedence that only the BOT can **establish** and **appoint** members of advisory committees. While both CEJA and CCB have confirmed that the HOD may request the Board to consider establishing an advisory committee via a letter or resolution, the BOT holds final authority over the creation and governance of advisory committees (see Bylaws [5.3](#), Duties and Privileges, and [2.13.6](#), Special Committees of the House of Delegates).

In doing its due diligence, CEJA identified some other Bylaw terminology associated with appointments and nominations that it believed were inconsistent and which it believed CCB should clarify for accuracy.

ADDITIONAL FACT-FINDING/BACKGROUND

CCB also reviewed past CLRPD documents related to AMA governance and the roles of the BOT and HOD. These confirmed the BOT as ultimately having fiduciary and management responsibility. The Office of the General Counsel has also confirmed the Board's exclusive authority over advisory committees.

The Council also reviewed Policy [G-615.003](#), AMA Member Component Groups, which includes the following definitions:

- An "advisory committee" is an entity whose activities relate to education and advocacy. An advisory committee will have a governing council and a direct reporting relationship to the BOT. Advisory committees, however, will not have representation in the HOD. Advisory committees will operate under a charter that will be subject to review and renewal by the BOT at least every four years.
- An "ad hoc committee" is a special committee, workgroup, or taskforce appointed by the BOT, the Speaker of the House, or the House of Delegates. These committees will operate for a specific purpose and for a prescribed period of time.

Overlapping Committee Terminology

The Bylaws currently use "special committee" in two distinct contexts:

1. Bylaw 2.13.6 allows the HOD to "establish special committees for specified terms of one to 3 years," with reports to the HOD through the Board.
2. Bylaw 5.3.10.2 states that a BOT ad hoc committee will be constituted as a special committee, workgroup or taskforce.

This shared label makes it unclear, when someone references a "special committee," whether it was created by the HOD or by the BOT, and which reporting and accountability rules apply.

Meanwhile, the advisory committee provisions in Bylaw 5.3.10.1 lack detail on how the Board actually establishes an advisory committee.

Under the proposed amendments, both the HOD and the Board retain their respective authority to create committees and time-limited bodies, but the originating authority determines the governance track:

- Committees and other bodies established by the HOD under Bylaw 2.13.6, regardless of their designated form, operate under the direction of the House, report to the House through the Board pursuant to Bylaw 2.13.6.1, and are subject to the terms established by the authorizing motion.
- Advisory committees and ad hoc bodies established by the Board under Bylaw 5.3.10 operate under the direction of and report directly to the Board, subject to the charter and term requirements set forth in Bylaws 5.3.10.1 and 5.3.10.2.

This approach eliminates the need to police labels across the two governance tracks and ensures that the authority, reporting structure, and accountability for any committee can be determined by reference to its authorizing provision rather than its name.

The Council presents the following proposed amended language to clarify existing bylaw language, provide consistent terminology and avoid future misunderstandings.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaw amendments and deletions (shown in red and amended by insertion or ~~deletion~~) 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

2.13.6 Special Committees of the House of Delegates. The House may establish special committees for specified terms of one to ~~3~~ three years. The number of members, the manner of their appointment and the functions of these committees shall be in accordance with motions authorizing their appointment. Any active member of the AMA is eligible to serve on a special committee of the House of Delegates. Members of special committees of the House of Delegates who are not members of the House of Delegates may present their reports in person to the House of Delegates and may participate in debate thereon, but are not entitled to vote in the House of Delegates. Special committees established under Bylaw 2.13.6 are distinct from committees appointed by the Board of Trustees under Section 5.3.10, and the term “special committee” as used in this Bylaw 2.13.6 refers exclusively to committees established by the House of Delegates.

2.13.6.1 Method of Reporting. Special Committees of the House of Delegates established under Bylaw 2.13.6 shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Special Committees as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modifications by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

2.13.6.2 Special committees of the House of Delegates, regardless of their designated form, shall operate under the direction of the House and report to the Board of Trustees pursuant to Bylaw 2.13.6.1.

2.13.7 Other Committees. The Speaker may establish ~~appoint~~ such other committees as may be desirable for the efficient transaction of business of the House of Delegates.

2.13.7.1 Appointment. The Speaker shall appoint the Chair and other members of the committees. Membership on these committees is restricted to delegates and alternate delegates.

5—Board of Trustees

5.1.1 Officers and Committees. Immediately following the conclusion of the Annual Meeting, the Board shall organize by electing a Chair-elect, and a Secretary, and by establishing committees necessary for its functions. The Chair shall appoint committee members.

5.3.10 Establishment and Appointment of Advisory and Ad Hoc Committees. ~~Appoint~~ Establish such advisory and ad hoc committees as necessary to carry out the purposes of the AMA and appoint their members. Committees appointed by the Board under Bylaw 5.3.10 are distinct from special committees established by the House of Delegates under Bylaw 2.13.6.

5.3.10.1 An advisory committee will be ~~constituted~~ established by a majority vote of the Board for purposes of education and advocacy.

5.3.10.1.1 ~~It~~ An advisory committee will have a governing council and a direct reporting relationship to the Board.

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

5.3.10.1.3 An advisory committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for governing council members, and reporting obligations. ~~The charter that~~ will be subject to review and renewal by the Board at least every four years.

5.3.10.2 An ad hoc committee will be ~~constituted~~ established by the Board as a ~~special committee,~~ workgroup or taskforce.

5.3.10.2.1 An ad hoc committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for members, and reporting obligations.

5.3.10.2.2 An ad hoc committee will not have representation in the House of Delegates.

~~5.3.10.2.4~~

5.3.10.2.3 ~~It~~ An ad hoc committee will operate for a specific purpose and for a prescribed period of time.

(Modify Bylaws)

CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

2—House of Delegates

2.13.6 Special Committees of the House of Delegates. The House may establish special committees for specified terms of one to three years. The number of members, the manner of their appointment and the functions of these committees shall be in accordance with motions authorizing their appointment. Any active member of the AMA is eligible to serve on a special committee of the House of Delegates. Members of special committees of the House of Delegates who are not members of the House of Delegates may present their reports in person to the House of Delegates and may participate in debate thereon, but are not entitled to vote in the House of Delegates. Special committees established under Bylaw 2.13.6 are distinct from committees appointed by the Board of Trustees under Section 5.3.10, and the term “special committee” as used in this Bylaw 2.13.6 refers exclusively to committees established by the House of Delegates.

2.13.6.1 Method of Reporting. Special Committees of the House of Delegates established under Bylaw 2.13.6 shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Special Committees as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modifications by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

2.13.6.2 Special committees of the House of Delegates, regardless of their designated form, shall operate under the direction of the House and report to the Board of Trustees pursuant to Bylaw 2.13.6.1.

2.13.7 Other Committees. The Speaker may establish such other committees as may be desirable for the efficient transaction of business of the House of Delegates.

2.13.7.1 Appointment. The Speaker shall appoint the Chair and other members of the committees. Membership on these committees is restricted to delegates and alternate delegates.

5—Board of Trustees

5.1.1 Officers and Committees. Immediately following the conclusion of the Annual Meeting, the Board shall organize by electing a Chair-elect and a Secretary, and by establishing committees necessary for its functions. The Chair shall appoint committee members.

5.3.10 Establishment and Appointment of Advisory and Ad Hoc Committees.

Establish such advisory and ad hoc committees as necessary to carry out the purposes of the AMA and appoint their members. Committees appointed by the Board under Bylaw 5.3.10 are distinct from special committees established by the House of Delegates under Bylaw 2.13.6.

5.3.10.1 An advisory committee will be established by a majority vote of the Board for purposes of education and advocacy.

5.3.10.1.1 An advisory committee will have a governing council and a direct reporting relationship to the Board.

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

5.3.10.1.3 An advisory committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for governing council members, and reporting obligations. The charter will be subject to review and renewal by the Board at least every four years.

5.3.10.2 An ad hoc committee will be established by the Board as a workgroup or taskforce.

5.3.10.2.1 An ad hoc committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for members, and reporting obligations.

5.3.10.2.2 An ad hoc committee will not have representation in the House of Delegates.

5.3.10.2.3 An ad hoc committee will operate for a specific purpose and for a prescribed period of time.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-26

Subject: Amendments to Bylaws governing the AMA Sections

Presented by: Mary Ann Contogiannis, MD, Chair

Referred to: Reference Committee on Ethics & Bylaws

1 Over the last year, the Board of Trustees (BOT), the AMA Sections and the Council on
2 Constitution and Bylaws (CCB) have been discussing the intertwined relationship between the
3 AMA Bylaws and the Sections' Rules, often referred to as Internal Operating Procedures (IOPs).
4 Per Bylaw 7.0.7, "All rules, regulations, and procedures adopted by each Section shall be subject to
5 the approval of the Board of Trustees."

6
7 By way of background, the IOPs initially came into being nearly 20 years ago to supplement details
8 not included in the Bylaws. In 2006, as part of a major Bylaw revision, the House of Delegates
9 (HOD) [voted to remove details](#) regarding section operations (governing council composition,
10 duties and responsibilities of governing council members, election procedures, meeting procedures
11 and deadlines, to IOPs rather than include them in the Bylaws. All sections were given a template
12 of elements that should be included in their IOPs; however, the individual section IOPs have been
13 modified frequently and significantly over the years. CCB, per Bylaw [6.1.1.4](#), has served as
14 advisory to the BOT in reviewing the rules, regulations, and procedures of the AMA Sections.

15
16 Recently, it became apparent that there is some duplication, some perceived conflicts between the
17 Bylaws and IOPs, and some inconsistent terminology, nomenclature and procedures. Over the last
18 year, the BOT, CCB and Section management and leadership have been collaborating to reach
19 consensus on what belongs in Bylaws rather than IOPs, with additional some decisions yet to be
20 finalized. The ultimate goal is to make both the Bylaws and IOPs transparent to all, minimize
21 redundancy and be consistent across sections where possible. Future amendments likely will
22 incorporate provisions to address any section or governing council activity that impacts the HOD.

23
24 As a starting point, CCB Report 8-A-26, Business Meetings of the Sections, provided flexibility as
25 to when and how Sections may convene their business meetings. The adopted amended language
26 allows a Section to convene business meetings prior to each HOD meeting without the prior
27 restriction that a meeting must occur "a day prior" to each HOD meeting. This change allows
28 Sections to convene virtual reference committees, finalize resolutions for submission to the HOD
29 and hold elections as necessary, with all these functions being components of a business meeting.
30 Other CCB reports adopted at A-26 provided additional details associated with section delegates to
31 the HOD.

32
33 To comport with guidance from the BOT, CCB has examined the other 'overarching' rules that
34 apply to the sections and has proposed changes in terminology for accuracy (namely disallowing
35 reference to officers) and proposed changes to provide clarity as to the BOT's authority over
36 sections and their IOPs. Unlike other groups with HOD delegate seats, the sections are funded and
37 staffed by AMA and do not function autonomously as do other HOD delegations. Explanatory
38 details regarding the Council's proposed changes are summarized below.

Summary of Proposed Changes

Officers – The AMA Constitution defines the officers of the AMA as “the President, President-Elect, Immediate Past President, Secretary, Speaker of the House of Delegates, Vice Speaker of the House of Delegates and the other members of the Board of Trustees.” Some individual section bylaws have also used the term officers to define the section leadership (chair, chair-elect, or vice chair). Within the section IOPs, there is no consistency: some consider all governing council members to be officers; some consider the chair, chair-elect (or vice chair) and immediate past chair to be the officers; and others do not use the term at all. Admittedly, current and long-standing bylaws reference section officers; however, as sections are HOD-established member component groups and funded by AMA with BOT oversight of their rules, CCB proposes to eliminate the term officers within both the section Bylaws and individual section IOPs to minimize confusion between the AMA Officers and section leaders.

Governing Council Member Qualifications – Some sections provide for a grace period to allow those who “age out” or “time out” of a section to continue service. CCB has proposed an amendment to acknowledge the existence of such provisions in the general bylaws that govern all sections.

Board Authority over IOPs – The AMA Constitution Article VI state that “The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations and such duties as prescribed in the Bylaws.” Bylaws 5.3 and its subprovisions expand on the BOT’s duties and privileges, with Bylaw 6.1.1.4 specifying CCB’s role of serving as advisory to the BOT in reviewing the rules, regulations and procedures of the AMA Councils and Sections. [CCB Report 3-I-12](#) which informed the House of Delegates about the differences between the AMA Bylaws and Section IOPs, noted “The Board of Trustees then reviews the updated IOP and decides whether or not to approve the proposed change.” CCB offers clarifying language to reflect the BOT’s authority over all governance decisions adopted by the Sections.

Updated Nomenclature re: Resident/Fellow Sectional Delegates – CCB’s proposed bylaw changes to 7.1.6 reflect updated bylaw nomenclature to reference the resident and fellow sectional delegates.

Provisions to Fill Vacant Governing Council Positions – Some existing bylaw language provides more specificity regarding governing council vacancies, with most such language stating that the position remains vacant, the implication being that the vacancy will be filled at the next business meeting at which elections take place. In practice, however, while many sections fill a vacant position by election at the next election cycle, other section-specific rules allow for temporary appointments until such time at there can be an election. The proposed bylaw changes are for the sake of consistency across sections. Additionally, existing AMA Bylaws include provisions for filling section delegate and alternate delegate vacancies.

Use of the term “this bylaw” – As this appears to be a generic phrase, CCB has added more specificity for clarity.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the Bylaws (shown in red and amended by insertion or ~~deletion~~) 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.

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. Each Section shall adopt rules governing the composition, election, terms and tenure of its Governing Council members. Each Section's The programs and activities, as well as its rules governing the composition, election, term and tenure of Governing Council members, shall be subject to the approval of the Board of Trustees ~~or the House of Delegates~~.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section, unless otherwise provided in a section-specific bylaw. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

7.0.3.2 Voting. Members of each Section Governing Council, including a chair and vice chair or chair-elect, shall be elected by the voting members of the Section present at the business meeting of the Section, unless otherwise provided in this Bylaw a section-specific bylaw.

~~**7.0.3.3 Additional Requirements.** Each Section shall adopt rules governing the composition, election, term, and tenure of its Governing Council.~~

~~**7.0.4 Officers.** Each Section shall select a Chair and Vice Chair or Chair Elect and other necessary and appropriate officers.~~

~~**7.0.4.1 Qualifications.** Officers of each Section must be members of the AMA and of the Section.~~

~~**7.0.4.2 Voting.** Officers of each Section shall be elected by the voting members of the Section, unless otherwise provided in this Bylaw.~~

~~**7.0.4.3 Additional Requirements.** Each Section shall adopt rules governing the titles, duties, election, term, and tenure of its officers.~~

7.0.4

~~**7.0.5**~~ **Delegate and Alternate Delegate.** Each Section shall elect a Delegate and Alternate Delegate to represent the Section in the House of Delegates, consistent with Bylaw 2.6.

7.0.5

7.0.6

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

7.0.5.1

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

7.0.5.1.1

7.0.6.1.1 To hear such reports and resolutions as may be appropriate.

7.0.5.1.2

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

7.0.5.1.3

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

7.0.5.1.4

To develop a section position on pending House of Delegates business items.

7.0.5.1.5

7.0.6.1.4 To hold elections for Governing Council members, unless otherwise specified in a section-specific bylaw.

7.0.6

7.0.7

Rules. All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees. The Board of Trustees may approve, not approve, or approve with required modifications.

7.1 Resident and Fellow Section. ***

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

7.1.6 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw ~~7.0.6.1~~ 7.0.5.1, the purposes of the meeting shall include:

7.1.6.1 To adopt procedures for election of the resident and fellow sectional delegates and alternate delegates ~~for the Resident and Fellow Section~~ established in Bylaw 2.4, subject to the approval of the Board of Trustees.

7.1.6.2 To elect, at the business meeting prior to the Interim Meeting of the House of Delegates AMA, resident and fellow sectional delegates and alternate delegates ~~for the Resident and Fellow Section~~. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.2 Academic Physicians Section. ***

7.2.2 **Elections.** Membership on the Governing Council shall be determined through election by members of the Academic Physicians Section. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.2.2.1 **Cessation of Eligibility.** If ~~any~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.2.1 prior to the expiration of the term for which elected, the term of such Governing Council member shall terminate and the position shall be declared vacant.

7.3 Medical Student Section. ***

7.3.2 **Cessation of Eligibility.** If ~~any officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 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 graduates from an educational program during their term, the ~~officer or~~ member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.3.4 **Additional Purposes of the Meeting.** In addition to the purposes of the Business Meeting set forth in Bylaw ~~7.0.6.1~~ 7.0.5.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the House of Delegates AMA, as provided in Bylaw 3.5.6.1.

7.3.4.2 To adopt procedures for election of ~~Medical Student Regional~~ medical student regional delegates and alternate delegates to the House of Delegates as established in Bylaw 2.3.3, subject to the approval of the Board of Trustees.

7.3.4.3 To elect ~~Medical Student Regional~~ medical student regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the House of Delegates AMA. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

- 1 **7.4 Organized Medical Staff Section. *****
2
3 **7.4.3 Cessation of Eligibility.** If ~~any officer or~~ Governing Council member ceases to
4 meet the membership requirements of Bylaw 7.4.1 or ceases to be credentialed as a
5 representative consistent with Bylaw 7.4.2 prior to the expiration of the term for
6 which elected, the term of such ~~officer or~~ member shall terminate and the position
7 shall be declared vacant.
8
9 **7.5 Young Physicians Section. *****
10
11 ***
12
13 **7.6 International Medical Graduates Section. *****
14
15 **7.6.2**
16 ~~**7.6.3**~~ **Elections.** Membership on the Governing Council shall be determined through
17 election by members of the IMG Section. Designation of specific offices of the
18 Governing Council members shall be determined through election by members of
19 the IMG Section present at the Section's Business Meeting at which the election is
20 held.
21
22 **7.6.2.1**
23 ~~**7.6.3.1**~~ **Election of Governing Council Members.** All members of the IMG
24 Section shall be entitled to vote in elections of membership of the
25 Governing Council. Ballot distribution and the voting process shall be
26 conducted pursuant to election procedures adopted by the Governing
27 Council and approved by the Board of Trustees.
28
29 **7.6.2.2**
30 ~~**7.6.3.2**~~ **Designation of Specific Offices. Election of the Chair-elect.** All
31 members of the IMG Section present at the Section's Business Meeting
32 shall be entitled to elect the Chair-elect from among those Governing
33 Council members elected by the Section. ~~Only R~~resident/fellow physicians
34 shall be eligible to be elected only to the resident/fellow physician member
35 ~~office position~~.
36
37 **7.6.3**
38 ~~**7.6.2**~~ **Cessation of Membership Eligibility.** If ~~any officer or~~ Governing Council
39 member ceases to meet the membership requirements of Bylaw 7.6.1 prior to the
40 expiration of the term for which elected, the term of such ~~officer or~~ member shall
41 terminate and the position shall be declared vacant.
42
43 **7.7 Underrepresented in Medicine Advocacy Section. *****
44
45 **7.7.2 Elections.** Membership on the Governing Council shall be determined through
46 election by members of the Underrepresented in Medicine Advocacy Section. All
47 members of the Underrepresented in Medicine Advocacy Section, except
48 provisional members, shall be entitled to vote in elections of Governing Council
49 members. Ballot distribution and the voting process shall be conducted pursuant to
50 election procedures adopted by the Governing Council and approved by the Board
51 of Trustees.

7.7.2.1 **Election of ~~Officers~~ the Chair and Vice Chair.** The Governing Council shall elect ~~its~~ a Chair and Vice Chair from among ~~the~~ those Governing Council members elected by the Section.

7.7.2.2 **Election of Alternate Delegate.** The Governing Council shall elect an Alternate Delegate from among those Governing Council members elected by the Section.

7.7.3 **Cessation of ~~Membership~~ Eligibility.** If ~~any officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 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.

7.7.3.1 **Designated Section Representative Member on the Governing Council.** If ~~a representative the designated member~~ of the Resident and Fellow Section or Young Physicians Section who has been elected to the Governing Council ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If ~~a representative the designated member~~ of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.7.3.2 **Designated Section Representative Member as Immediate Past Chair.** A ~~designated~~ Section ~~representative member~~ who has been elected as Chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as ~~the officer they~~ remains an active physician member of the AMA.

7.8 Integrated Physician Practice Section. ***

7.8.2 **Governing Council ~~and Officers~~.** Only Associate Members of the Section are eligible to ~~hold office or~~ serve on the Governing Council and vote in elections and on items of business.

7.8.3 **Cessation of ~~Membership~~ Eligibility.** If a Governing Council member ceases to meet the membership requirements of Bylaw 7.8.1.1 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 ~~and a successor will be elected~~.

- 1 **7.9 Senior Physicians Section. *****
2
3 **7.9.2 Elections.** Membership on the Governing Council shall be determined through
4 election by members of the Senior Physicians Section. All members of the Senior
5 Physicians Section shall be entitled to vote in elections of Governing Council
6 members. Ballot distribution and the voting process shall be conducted pursuant to
7 election procedures adopted by the Governing Council and approved by the Board
8 of Trustees.
9
10 **7.9.2.1 Election of Chair-Elect, Officers.** The Governing Council shall elect ~~the~~
11 ~~Section its~~ Chair-Elect from among ~~the~~ those Governing Council members
12 elected by the Section.
13
14 **7.9.3 Cessation of Membership Eligibility.** If ~~an officer or~~ Governing Council member
15 ceases to be an active member of the AMA prior to the expiration of the term for
16 which elected, the term of such ~~officer or~~ member shall terminate and the position
17 shall be declared vacant.
18
19 **7.10 Women Physicians Section. *****
20
21 **7.10.2 Elections.** Membership on the Governing Council shall be determined through
22 election by members of the Women Physicians Section. All members of the
23 Women Physicians Section shall be entitled to vote in elections of Governing
24 Council members. Ballot distribution and the voting process shall be conducted
25 pursuant to election procedures adopted by the Governing Council and approved
26 by the Board of Trustees.
27
28 **7.10.2.1 Election of Officers Governing Council Leadership.** The Governing
29 Council shall elect its Chair and Vice Chair from among the Governing
30 Council members.
31
32 **7.10.3 Cessation of Membership Eligibility.** If ~~an officer or~~ Governing Council member
33 ceases to be an active member of the AMA prior to the expiration of the term for
34 which elected, the term of such ~~officer or~~ member shall terminate and the position
35 shall be declared vacant.
36
37 **7.11 Private Practice Physicians Section.** The Private Practice Physicians Section is a
38 delineated Section.
39
40 ***
41
42 **7.11.3 Cessation of Membership Eligibility.** If ~~an officer or~~ Governing Council
43 member ceases to meet the membership requirements of Bylaw 7.11.1 prior to
44 the expiration of the term for which elected, the term of such officer or member
45 shall immediately terminate and the position promptly shall be declared vacant.
46
47 **7.12 LGBTQ+ Section.** The LGBTQ+ Section is a delineated Section.
48
49 ***

7.12.2 Elections. Any Section member is eligible to ~~hold office or~~ serve on the Governing Council. All members of the Section shall be entitled to vote in elections. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Section and approved by the Board of Trustees.

7.12.2.1 The Governing Council shall ~~annually~~ elect its Chair and Vice Chair from among the Governing Council members elected by Section members.

7.12.3

7.12.2.2 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.12.1 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 ~~and a successor will be elected.~~

7.12.3.1

7.12.2.3 Cessation of Eligibility of Designated Section Members. If ~~any~~ the ~~designated member of the Resident and Fellow Section~~ resident/fellow or ~~young physician member~~ Young Physicians Section who has been elected to of the governing council ceases to meet the criteria for membership in their respective section ~~they represent~~ within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If the designated member of the Medical Student Section ~~any medical student member~~ graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

(Modify Bylaws)

1

CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. Each Section shall adopt rules governing the composition, election, terms and tenure of its Governing Council members. Each Section's programs and activities, as well as its rules governing the composition, election, term and tenure of Governing Council members, shall be subject to the approval of the Board of Trustees.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section, unless otherwise provided in a section-specific bylaw. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

7.0.3.2 Voting. Members of each Section Governing Council, including a chair and vice chair or chair-elect, shall be elected by the voting members of the Section present at the business meeting of the Section, unless otherwise provided in a section-specific bylaw.

7.0.4 Delegate and Alternate Delegate. Each Section shall elect a Delegate and Alternate Delegate to represent the Section in the House of Delegates, consistent with Bylaw 2.6.

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

7.0.5.1 Purpose. The purposes of the Business Meeting shall be:

7.0.5.1.1 To hear such reports and resolutions as may be appropriate.

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

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

7.0.5.1.4 To develop a section position on pending House of Delegates business items.

7.0.5.1.5 To hold elections for Governing Council members, unless otherwise specified in a section-specific bylaw.

- 7.0.6 Rules.** All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees. The Board of Trustees may approve, not approve, or approve with required modifications.

7.1 Resident and Fellow Section. ***

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

- 7.1.6 Additional Purposes of the Meeting.** In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.5.1, the purposes of the meeting shall include:

7.1.6.1 To adopt procedures for election of the resident and fellow sectional delegates and alternate delegates established in Bylaw 2.4, subject to the approval of the Board of Trustees.

7.1.6.2 To elect, at the business meeting prior to the Interim Meeting of the House of Delegates, resident and fellow sectional delegates and alternate delegates. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.2 Academic Physicians Section. ***

7.2.2 Elections. Membership on the Governing Council shall be determined through election by members of the Academic Physicians Section. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.2.2.1 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.2.1 prior to the expiration of the term for which elected, the term of such Governing Council member shall terminate and the position shall be declared vacant.

7.3 Medical Student Section. ***

7.3.2 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If the member graduates from an educational program during their term, the member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.3.4 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.5.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the House of Delegates, as provided in Bylaw 3.5.6.1.

7.3.4.2 To adopt procedures for election of medical student regional delegates and alternate delegates to the House of Delegates as established in Bylaw 2.3.3, subject to the approval of the Board of Trustees.

7.3.4.3 To elect medical student regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the House of Delegates. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.4 Organized Medical Staff Section. ***

7.4.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.4.1 or ceases to be credentialed as a representative consistent with Bylaw 7.4.2 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.5 Young Physicians Section. ***

7.6 International Medical Graduates Section. ***

7.6.2 Elections. Membership on the Governing Council shall be determined through election by members of the IMG Section. Designation of specific offices of the Governing Council members shall be determined through election by members of the IMG Section present at the Section's Business Meeting at which the election is held.

7.6.2.1 Election of Governing Council Members. All members of the IMG Section shall be entitled to vote in elections of membership of the Governing Council. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.6.2.2 Election of the Chair-elect. All members of the IMG Section present at the Section's Business Meeting shall be entitled to elect the Chair-elect from among those Governing Council members elected by the Section. Resident/fellow physicians shall be eligible to be elected only to the resident/fellow physician member position.

7.6.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.6.1 prior to the expiration of the term for

which elected, the term of such member shall terminate and the position shall be declared vacant.

7.7 Underrepresented in Medicine Advocacy Section. ***

7.7.2 Elections. Membership on the Governing Council shall be determined through election by members of the Underrepresented in Medicine Advocacy Section. All members of the Underrepresented in Medicine Advocacy Section, except provisional members, shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.7.2.1 Election of the Chair and Vice Chair. The Governing Council shall elect a Chair and Vice Chair from among those Governing Council members elected by the Section.

7.7.2.2 Election of Alternate Delegate. The Governing Council shall elect an Alternate Delegate from among those Governing Council members elected by the Section.

7.7.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.7.3.1 Section Member on the Governing Council. If a member of the Resident and Fellow Section or Young Physicians Section who has been elected to the Governing Council ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a member of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.7.3.2 Section Member as Immediate Past Chair. A Section member who has been elected as Chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as they remain an active physician member of the AMA.

7.8 Integrated Physician Practice Section. ***

7.8.2 Governing Council. Only Associate Members of the Section are eligible to serve on the Governing Council and vote in elections and on items of business.

7.8.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.8.1.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.9.2.1 Election of Chair-Elect. The Governing Council shall elect a Chair-Elect from among those Governing Council members elected by the Section.

7.9 Senior Physicians Section. ***

7.9.2 Elections. Membership on the Governing Council shall be determined through election by members of the Senior Physicians Section. All members of the Senior Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.9.2.1 Election of Chair-Elect. The Governing Council shall elect its Chair-Elect from among those Governing Council members elected by the Section.

7.9.3 Cessation of Eligibility. If a Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.10 Women Physicians Section. ***

7.10.2 Elections. Membership on the Governing Council shall be determined through election by members of the Women Physicians Section. All members of the Women Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.10.2.1 Election of Governing Council Leadership. The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members.

7.10.3 Cessation of Eligibility. If a Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.11 Private Practice Physicians Section. ***

7.11.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.11.1 prior to the expiration of the term for which elected, the term of such member shall immediately terminate and the position promptly shall be declared vacant.

7.12 LGBTQ+ Section. The LGBTQ+ Section is a delineated Section.

7.12.2 Elections. Any Section member is eligible to serve on the Governing Council. All members of the Section shall be entitled to vote in elections. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Section and approved by the Board of Trustees.

7.12.2.1 The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members elected by Section members.

7.12.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.12.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.12.3.1 Cessation of Eligibility of Designated Section Members. If the designated member of the Resident and Fellow Section or Young Physicians Section who has been elected to the governing council ceases to meet the criteria for membership in their respective section within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If the designated member of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-26

Subject: Autonomy of House of Delegate Member Entities: Bylaw Clarification

Presented by: Mary Ann Contogiannis, MD, Chair

Referred to: Reference Committee on Ethics & Bylaws

Following the adoption of several reports of the Council on Constitution and Bylaws (CCB) at the last House of Delegates meeting (HOD), some questions have arisen from AMA leadership, Federation members and individual members of the AMA Sections regarding the accuracy of AMA Bylaw language that discusses the autonomy of the various entities represented in the HOD.

The HOD comprises delegates and alternate delegates from the following types of independent legally constituted entities: constituent associations (US geographical medical societies), national medical specialty societies (scientific specialties and subspecialty organizations, with admittance and continued representation governed by the AMA [Specialty and Service Society](#)), professional interest medical associations (physician organizations who represent their members' ethnic, cultural, demographic, minority or other interests, with admittance and continued representation governed by the SSS), the federal services (Army, Navy, Air Force, US Public Health Service and the Chief Medical Director of the Department of Veterans Affairs), the National Medical Association, the American Medical Women's Association, and the American Osteopathic Association. The HOD also includes delegates from the AMA Sections ([Medical Student Section](#), [Resident and Fellow Section](#), [Young Physicians Section](#), [Senior Physicians Section](#), [International Medical Graduates Section](#), [Underrepresented in Medicine Advocacy Section](#), [LGBTQ+ Section](#), [Academic Physicians Section](#), [Integrated Physicians Practice Section](#), [Organized Medical Staff Section](#), [Women Physicians Section](#), and [Private Practice Physicians Section](#)). The AMA Sections are [member component groups](#) and are funded and staffed by AMA. The Sections were formed to give [voice to a distinct group of AMA members](#) who were underrepresented in the HOD. Additionally, the HOD includes the [medical student regional delegates](#) and the [resident and fellow sectional delegates](#). These individuals are elected either by the MSS or the RFS, have a requisite endorsement from a constituent association, a national medical specialty society or professional interest medical association, with their funding derived from various sources (self-funding, constituent society, specialty society, or educational program).

To be accurate and minimize further confusion, CCB has proposed some bylaw amendments to clarify the autonomy of these various represented entities.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the Bylaws (shown in **red** and amended by **insertion** or **deletion**) 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. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

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

7—Sections

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.0.1.1 Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

7.0.1.2 Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

7.0.1.3 Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

7.0.1.4 Membership. To promote AMA membership growth.

7.0.1.5 Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

7.0.1.6 Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

7.0.1.7 Support. Sections are established by the House of Delegates as Member Component Groups of the AMA, function under Rules approved by the Board of Trustees, and do not function autonomously. While the Sections may generate internal section positions to guide their advocacy within the House of Delegates, they may only create policy through the House of Delegates and are bound by AMA policy outside of the HOD. Section governing council members are not officers of the AMA and are not permitted to speak on behalf of the AMA, unless explicitly designated to do so by the Board of Trustees.

(Modify Bylaws)

RELEVANT AMA POLICY

G-615.002, AMA Member Component Groups. A "Section" is a formal group of physicians or medical students directly involved in policymaking through a delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Each Section will continue to have representation in the House of Delegates. There will be two types of Sections, fixed and delineated.

"Fixed Sections" will represent the natural cycles related to a physician's career span. Since members of these groups would have limited opportunities for representation through their state/specialties societies, the need for focused representation will be enduring.

"Delineated Sections" will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented. These Sections will often be based on demographics or mode of practice. Delineated Sections will have a single delegate and alternate delegate in the HOD, and will operate under Internal Operating Procedures approved by the Board of Trustees. Delineated Sections will be reviewed every 5 years by the Council on Long Range Planning, which will make recommendations through the Board of Trustees to the House of Delegates, for renewal of the Section, based on criteria adopted by the House. The review provision allows for fluidity in the Association's structure as the activities and impact of the member groups are routinely evaluated.

G-615.001, Establishment and Function of Sections

1. Our American Medical Association adopts the following criteria in consideration of requests for establishing new **sections** or changing the status of member component groups:
 - a. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.
 - b. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.
 - c. Appropriateness - The structure of the group will be consistent with its objectives and activities.
 - d. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate.
 - e. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.
 - f. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.
2. Our AMA will consider requests for establishing new **sections** by letter of application to the CLRPD, which will make recommendations to the BOT and HOD for further action or by submission of a resolution.

CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

2—House of Delegates

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

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

7—Sections

- 7.0.1 Mission of the Sections.** A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

- 7.0.1.1 Involvement.** To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

- 7.0.1.2 Outreach.** To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

- 7.0.1.3 Communication.** To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

- 7.0.1.4 Membership.** To promote AMA membership growth.

- 7.0.1.5 Representation.** To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

- 7.0.1.6 Education.** To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

- 7.0.1.7 Support.** Sections are established by the House of Delegates as Member Component Groups of the AMA, function under Rules approved by the Board of Trustees, and do not function autonomously. While the Sections may generate internal section positions to guide their advocacy within the House of Delegates, they may only create policy through the House of Delegates and are bound by AMA policy outside of the HOD. Section governing council members are not officers of the AMA and are not permitted to speak on behalf of the AMA, unless explicitly designated to do so by the Board of Trustees.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-I-26

Subject: Preserving Autonomy in the Patient-Physician Relationship

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the AMA House of Delegates adopted Policy [D-140.944](#), “Preserving Autonomy in the Patient-Physician Relationship,” which states:

Our American Medical Association will 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.

This report is submitted for the information of the House of Delegates in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address outside political and administrative impact on the patient-physician relationship and shared decision-making.

BACKGROUND

There is a general sense among physicians that as medicine continues down a path of market consolidation and deprofessionalization, physicians are losing autonomy to the detriment of patient care and wellbeing, and that they are facing increasing pressure and overreach by political actors and administrators.¹ A 2025 survey by The Physicians Foundation found that 91 percent of physicians believe that loss of autonomy is a major threat that will exacerbate the physician shortage, with potentially grave impacts for patients.² In today’s heightened political climate, certain physician specialties have raised warnings about governmental incursion into their medical practices, negatively impacting the patient-physician relationship and shared decision-making. Research on physicians who provide family planning care,³ obstetrician-gynecologists,⁴ neonatology and pediatrics,⁵ and physicians who provide gender-affirming care⁶ all suggest that bans and other forms of political influence undermine evidence-based practices, negatively impact the patient-physician relationship and shared decision-making, and ultimately harm patients.

ETHICS ISSUE

Society has an obligation to support, or at minimum not to impede, the practice of medicine. However, many people today feel that this social obligation is being infringed upon or even overtly ignored. Physicians are frustrated by what many see as increasing outside political and administrative influences on the patient-physician relationship and their impact on shared decision-making in the clinical setting. There are valid concerns that these influences constrain physicians from practicing medicine in an ethically or professionally appropriate manner. At question is

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whether the AMA's *Code of Medical Ethics* adequately addresses outside political and administrative influence. It is important to bear in mind that the *Code* is only upheld by physicians, it is an ethics document without legal force in most cases (though some states have enshrined the *Code* in their state's laws), and any such changes are unlikely to reduce the influences of outside political and administrative forces.

RELEVANT AMA POLICY PROVISIONS

Substantial policy exists to uphold and protect the patient-physician relationship and shared medical decision-making. Multiple policies specifically outline our AMA's opposition to political interference with clinical care. Policy [H-140.835](#), "Political Interference in the Patient-Physician Relationship," states that our AMA opposes any policies that interfere with the patient-physician relationship or that impose legislative barriers to medical decision-making. Policy [H-373.995](#), "Government Interference in Patient Counseling," upholds the sanctity of the physician-patient-family relationship and opposes state and/or federal interference that may compromise a physician's ability to deliver quality care or effective communication without a compelling evidence-base. And Policy [H-270.959](#), "AMA Stance on the Interference of the Government in the Practice of Medicine," is explicit: "[o]ur American Medical Association opposes the interference of government in the practice of medicine".

With respect to administrative influence, Policy [H-160.887](#), "Corporate Practice of Medicine," acknowledges the potential risk to the patient-physician relationship posed by the corporatization of medicine and, indirectly, any associated administrative overreach. Policy [H-165.837](#), "Protecting the Patient-Physician Relationship," outlines that physicians have an obligation to advocate for patients as a means to protect and support the patient-physician relationship, which can be understood to include advocacy in light of either negative political or administrative influences. And Policy [D-140.948](#), "The Preservation of the Primary Care Relationship," directs our AMA to "uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives."

Importantly, our AMA has established a task force charged with preserving the patient-physician relationship, as directed by Policy [G-605.009](#), "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted." This task force is obligated to present annual reports on their work with recommendations for future actions, as outlined in by Policy [D-5.998](#), "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," and Policy [D-605.982](#), "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance."

RELEVANT CODE OPINIONS

The *Code of Medical Ethics* is quite clear on the sanctity of the patient-physician relationship and the importance of shared decision-making, and repeatedly outlines physicians' ethical obligations to support and uphold them. Nowhere is this more clearly defined than in the opening opinion to the *Code*, [Opinion 1.1.1](#), "Patient Physician Relationships," which was recently revised and adopted at the 2025 Interim Meeting, and which added language specifically addressing outside influences. The body of that newly adopted report directly addressed financial, political, and administrative influences, and new language in the opinion states, "[w]hen 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."

1 Additionally, [Opinion 11.1.4](#), “Financial Barriers to Health Care Access,” states that all
2 stakeholders, including policymakers and administrators, must work together to ensure access to
3 appropriate care. [Opinion 11.2.1](#), “Professionalism in Health Care Systems,” outlines that
4 physicians have an ethical responsibility to hold leadership accountable and to advocate for change
5 if policies create barriers to equal access to high-quality care. [Opinion 11.2.3](#), “Contracts to Deliver
6 Health Care Services,” states that all physicians “who act within their capacity as a physician, even
7 as administrators or intermediaries, also have a duty to uphold the ethical obligations of the
8 medical profession.” [Opinion 11.2.4](#), “Transparency in Health Care,” stipulates that physicians
9 have an obligation to inform patients of any information that may influence treatment
10 recommendations or care, which could include political or administrative constraints. And [Opinion](#)
11 [11.2.7](#), “Responsibilities to Promote Equitable Care,” states that hospitals and other healthcare
12 institutions share a duty with physicians to ensure that patient care is “safe, effective, patient
13 centered, timely, efficient, and equitable.”

14 15 ETHICS ANALYSIS & CONCLUSION

16
17 The issue of political, outside, and systems-level influence on the provision of health care and on
18 the patient-physician relationship, specifically, has recently been addressed by CEJA reports on
19 revised Opinion 1.1.1 “Patient-Physician Relationships” and the new report on “Health Care
20 Systems.” Several additional *Code* opinions emphasize the importance and ethical obligation of
21 physician advocacy and physicians’ duty to be transparent with patients, which could be interpreted
22 to include disclosure of outside political or administrative influences that impact the provision of
23 care. There is also significant relevant AMA policy on the issue. The matter of protecting the
24 patient-physician relationship and shared medical decision-making is of vital importance. CEJA
25 would like to acknowledge the work of the AMA Task Force to Preserve the Patient-Physician
26 Relationship and acknowledge the substantive ethics policy outlined in the *Code* that supports their
27 work.

28
29 The *Code of Medical Ethics* and related AMA policies are clear that the patient-physician
30 relationship and the process of shared medical decision-making that occurs within that relationship
31 must be upheld and protected from any negative outside influence.

32 33 RECOMMENDATIONS

34
35 The Council on Ethical and Judicial affairs recommends that Policy D-140.944 be rescinded as
36 having been accomplished by this report.

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-26

Subject: Clarifying Conscientious Objection

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the AMA House of Delegates adopted Policy [D-140.945](#), “Clarifying Conscientious Objection,” which states:

1. Our American Medical Association will 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.
2. Our AMA will 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.

This report is submitted for the information of the House of Delegates in fulfillment of the second directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician conscientious objection, discrimination, and equitable access to care. Board of Trustees Report 22-I-26, “Clarifying Conscientious Objection,” addresses the first directive separately.

BACKGROUND

Over the past decade, there has been a growing focus on physician exercise of conscientious objection and the tension between upholding physician autonomy while also protecting patients and patient populations from discrimination.¹⁻⁶ Proponents of conscientious objection believe that it is essential to ensuring physicians maintain independent professional judgments and acts as a check against external influence by the state and administrative pressures.¹ Critics of conscientious objection point to a legal history of conscientious objection clauses as stemming from religious anti-abortion beliefs and argue that the practice is harmful and derogatory.² As legal protections for physicians to exercise conscientious objection of care continue to grow, moving well beyond issues of abortion to include the provision of contraception, sterilization, gender-affirming care, and other services, there is valid concern that the practice is being used to target specific groups of patients, placing physician choice above patient’s rights.^{3,7,8}

ETHICS ISSUE

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Physicians maintain the right to exercise their conscience to practice medicine in alignment with “well-considered, deeply held beliefs that are central to their self-identities” ([Opinion 1.1.7](#)). Therefore, physicians may conscientiously object to initiating a patient-physician relationship or treating a patient in keeping with their beliefs as outlined in the *Code of Medical Ethics*. An ethical issue emerges, however, when a physician exercises their conscience in such a way that it rises to the level of discrimination against an individual patient or patient population. The primary concern raised by the second directive of Policy D-140.945, “Clarifying Conscientious Objection,” is whether the *Code* sufficiently protects patients and the profession against such instances of discrimination.

RELEVANT *CODE* OPINIONS

Several opinions in the AMA *Code of Medical Ethics* pertain to the issues surrounding physicians exercising conscientious refusal of care. [Opinion 1.1.7](#), “Physician Exercise of Conscience,” clearly states that physicians may ethically act or refrain from acting in accordance with their conscience but that their actions may not discriminate or unduly burden individual patients or patient populations and must not violate their professional obligations. This includes exercising their conscience while simultaneously upholding their obligations to patient rights ([Opinion 1.1.2](#)) and providing equitable care ([Opinion 11.2.7](#)). [Opinion 1.1.2](#) “Prospective Patients,” similarly states that physicians must not discriminate against prospective patients on the basis of non-clinically relevant characteristics. The aforementioned *Code* opinions, as well [Opinion 1.1.3](#) “Patient Rights,” clearly oppose invidious discrimination.

The [Principles](#) laid out in the *Code of Medical Ethics*, taken as a whole, likewise support physicians’ right to exercise conscience within legal, professional, and ethical constraints that protect patients and uphold their rights to respect and human dignity. Importantly, Principle IX is explicit that physicians have an ethical and professional responsibility to “support access to medical care for *all* people” (emphasis added).

ETHICS ANALYSIS & CONCLUSION

The growing focus, both legal and professional, on physician exercise of conscience to refuse care to patients should continue to be monitored. While physicians must be allowed the freedom to exercise their independent professional judgment and uphold their autonomy, such rights should not come at the cost of harming individual patients or patient populations. As outlined in the *Code of Medical Ethics*, physicians have a right to exercise their conscience so long as doing so does not constitute discrimination ([Opinions 1.1.2, 1.1.7](#)). Physicians have an ethical and professional obligation to uphold the patient-physician relationship through a commitment to act in the patient’s best interest, respect patients as persons, provide clear communication, and maintain professional competence ([Opinion 1.1.1](#)). For physician conscience, this entails an obligation to communicate clearly and respectfully with patients about any decision to refuse to provide care and to also provide a referral to ensure the rights of patients are respected. The *Code of Medical Ethics* and its corresponding Principles are clear that a physician’s right to choose their patients is appropriately limited by their duty to provide equitable access to care.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the second directive of Policy D-140.945 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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REPORT 03 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Guidelines on Chaperones for Sensitive Exams

EXECUTIVE SUMMARY

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-I-26

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

[Policy D-140.950](#), “Guidelines on Chaperones for Sensitive Exams,” was adopted at the 2022 Interim Meeting and reads as follows:

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

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

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

BACKGROUND

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

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1 explanations of various components of the physical examination. They also include the use of
 2 chaperones regardless of the gender of the physician or patient.²

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

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

18
 19 In most instances, only an authorized member of the healthcare team should serve as a chaperone
 20 and understand the responsibilities of the role. Broadly speaking, chaperones should be provided
 21 with information regarding⁵:

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

33 Expert consensus is that individuals for whom patient care is not a routine part of their ordinary
 34 duties (such as front desk or office support staff) should not function as chaperones.^{1,6} It may be
 35 appropriate for medical students, residents, and fellows to perform the duties of a chaperone,
 36 provided that special attention is paid to how these duties may be impacted by the power imbalance
 37 inherent in the trainee-supervisor relationship. Trainees should be provided with information about
 38 their role serving as a chaperone, sufficient knowledge about the procedure or interaction they will
 39 be observing, and how to report any concerns without repercussions, fear of retaliation, or other
 40 professional disadvantages.

41
 42 The standard approach is to have healthcare staff (such as nurses, medical assistants, or physician
 43 assistants) act as chaperones, provided they are fully trained in the responsibilities of the role.
 44 Occupying a dual role as chaperone and member of the care team is acceptable when the two sets
 45 of responsibilities do not conflict and are well understood by everyone involved. "Parents and other
 46 untrained individuals" should not act as chaperones, except in the case of young children.^{3,6}

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

on methods of communication to signal patient distress or chaperone concerns while examinations or procedures are in progress.³

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

ETHICS ISSUES

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

DISCUSSION

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

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

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

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

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

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

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

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice regarding the presence of a chaperone.¹⁰ Under ordinary circumstances, remaining silent should not be understood as valid consent.

Both opt-in and opt-out policies can create challenges in part because patients’ requests and/or consent for use of a chaperone take place directly in the treatment room. For this reason, it has been suggested that patients’ preferences regarding chaperones should be solicited by front desk staff or other intake staff as a routine part of the check-in procedure.^{4,8} This approach is an opportunity to provide materials explaining the purpose of the chaperone and to inform patients of the standard policy while allowing patients to express their preferences in a low-pressure environment. However, regardless of where and how consent for the use of a chaperone is solicited and obtained, physicians should keep in mind that what is most important during “the process of obtaining consent is equalizing the patient’s ability to say *yes* or to say *no*.”¹¹

Documentation of Chaperone Use

Regardless of the chaperone policy implemented in a particular setting, the medical record should document the presence or absence of a chaperone for each sensitive examination.^{1,3,8} For all examinations or procedures in which a chaperone is present, the medical record should reflect whether the patient requested a chaperone explicitly or whether one was present as a matter of policy. Additionally, the name of the chaperone present and any patient preferences regarding the use of a chaperone should also be documented. Note that there is a range of acceptable practices for

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

3 4 *Patients with Diminished or Lacking Decisional Capacity*

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

13 14 *Patient Preferences Regarding Chaperones*

15
16 With regard to patient preference for specific characteristics of a chaperone (such as gender or
17 religious affiliation), physicians should be respectful of the patient's values and preferences while
18 also being mindful not to accede to discriminatory or disruptive patient demands. Disrespectful,
19 derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of
20 personal preferences on the part of either patients or physicians, can undermine trust and
21 compromise the integrity of the patient-physician relationship while also creating an "environment
22 that strains relationships among patients, physicians, and the health care team" ([Opinion 1.2.2](#)).
23 Discriminatory requests should not typically be accommodated, and accommodation should only
24 occur after careful weighing of the circumstances. Patients' preferences, if nondiscriminatory,
25 should be respected, documented, and upheld within reason and feasibility.

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

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

The Use of a Chaperone without Patient Consent in Exceptional Circumstances

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

- When it is an emergency and failure to proceed rapidly would result in an immediate risk to the patient's life or long-term health; or
- In cases where the integrity of the patient-physician relationship is at risk, such as when a patient's behavior compromises (or has previously threatened or crossed) professional boundaries or the physician has reason to believe such a boundary violation or other unsafe situation is likely to occur.¹³

Pediatric & Adolescent Patients

Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from that of adult patients because they have different needs and sensitivities. Normally, a parent or guardian may act as the chaperone for young pediatric patients (from newborns to children aged 11 years).¹⁴ In cases where a parent or guardian is unavailable or their presence would interfere with the examination (such as in cases of suspected abuse), another chaperone should be present.¹⁴ Should a parent or guardian decline the physician's request that a chaperone be present in such situations, it may nevertheless be appropriate for the physician to insist that a chaperone be present for the sake of patient safety.

Addressing the needs of adolescent patients (aged 12-17 years) is more complex. Since many adolescents are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for increased privacy," any examination that requires them to remove their clothes could be distressing.⁹ Physicians should not assume that their own definitions of a sensitive examination reflect the understanding of the individual teenage patient.¹⁵ Research shows that 60 percent to 70 percent of female adolescents would like the option of a chaperone for both standard and sensitive examinations. Only 21 percent indicated that they would ask for a chaperone if one was not offered, and substantially more female adolescents wanted a chaperone for sensitive examinations if they had a chaperone in the past.⁹

Many adolescents want a parent to act as chaperone instead of a healthcare professional, although in general as their age increases their preference for a non-parent chaperone also increases.¹⁵ Some adolescents do not wish to have chaperones, indicating that it would be more embarrassing, awkward, or uncomfortable to have an additional person in the room.⁸

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

As noted in [Opinion 2.2.1](#), "Pediatric Decision Making," the "more mature a minor patient is [...] the stronger the ethical obligation to seek minor patients' assent." This obligation extends to their assent for the presence of a chaperone, as well as their preferences for who the chaperone will be

1 and the gender of the chaperone. In general, physicians and parents/guardians should respect a
2 minor's refusal to assent to a chaperone (except under the exceptions outlined above when a
3 physician may either insist on a chaperone or may decline to proceed with the examination for
4 emergency or safety reasons).

5
6 Policies around the use of chaperones for adolescents are separate from issues of parental consent
7 for treatment. Physicians should be aware that, "[in] some jurisdictions, the law permits minors
8 who are not emancipated to request and receive confidential services relating to contraception, or to
9 pregnancy testing, prenatal care, and delivery services" or to prevent, diagnose, or treat sexually
10 transmitted disease without parental consent and/or notification ([Opinion 2.2.2](#)). Once the legally
11 required consent has been obtained, the minor patient's preferences concerning use of chaperones
12 can be discussed.⁶

13 14 ETHICS ANALYSIS

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

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

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

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

47
48 Since patients may not disclose their history of sexual assault or previous negative healthcare
49 experiences, trauma-informed care (sometimes alternatively described as "healing-centered
50 engagement"¹⁶) should be employed for all examinations, including those not usually understood as
51 sensitive. A trauma-informed framework "assumes that all people have experienced trauma, may

be currently experiencing it, or will experience it in the future.”¹¹ This approach is focused on creating “safety, empowerment, and trustworthiness” in the clinical encounter.¹⁷

For sexual and gender minority patients, their lived experiences, perspectives, and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive.¹⁷ Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient’s level of comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for all patients is to be open to broadening the range of circumstances in which a chaperone is used.

The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate behavior.¹ Patients may be more comfortable with someone of a particular gender being present because that person can better understand the kinds of embarrassment or discomfort associated with their sensitive exam and so may be better equipped to provide support.¹⁸

While opt-in chaperone policies have historically been regarded as adequate, this is no longer the case for some specialties. There is evidence that a shift to opt-out policies will better protect both patients and physicians in many settings. ACOG argues that given “the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone,” regular use of chaperones is necessary to assure patients and the public that significant “efforts [are being made] to create a safe environment for all patients.”¹ Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Similarly, the American College Health Association supports the adoption of opt-out chaperone policies and recommends that every medical institution have a policy regarding sensitive examinations “to protect patients’ safety and minimize risk associated with the performance of these exams” that should include the presence of a chaperone for such exams.⁵

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

CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that the use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Chaperones must

be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient. As far as possible, lines of authority in the reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter.³ Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care. While there are valid concerns related to funding, training, and staffing chaperones, these challenges do not supersede the ethical obligation to provide a chaperone to patients during sensitive examinations and procedures. If physicians cannot uphold this ethical obligation, they should work with their administrators and specialty associations to seek guidance for remediating the situation.

RECOMMENDATION

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

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

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

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

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

- (a) Make every reasonable effort to provide a chaperone for all sensitive exams, regardless of patient capacity, unless a delay in obtaining a chaperone would result in significant harm to the patient.
- (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam:

- i. if the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician;
 - ii. in emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale.
- ~~(e) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~
- ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~
- ~~(e)(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present.~~
- (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries.
- (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or if their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision-making between patient and physician.
- All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk.
- For nonsensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request.
- (Modify HOD/CEJA Policy)
2. Policy D-140.950 be rescinded, as it has been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal.

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REPORT 04 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

EXECUTIVE SUMMARY

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

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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 04-I-26

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

Presented by: Larry Reaves, 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.

In response to testimony at the 2026 Annual Meeting, CEJA has changed “could” to “would predictably” in subsection (iii) of recommendation (b). CEJA also wishes to highlight that, contrary to the current version of the *Code*, which prohibits physicians from striking, the proposed use of “should avoid” is not a prohibition and does not mean physicians must never engage in such actions. The recommendations presented in this report do not prohibit physicians from striking but rather lay out the ethical obligations under which such disruptive collective actions may take place.

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities.¹ Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019.² As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1

* 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.

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 healthcare 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 healthcare 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 reinvigorating the organized medical 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 healthcare 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 healthcare 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 underappreciated 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 healthcare 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

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

7 *Additional Relevant Policy*

8
 9
 10 The World Medical Association recommends that physicians adopt the following guidelines
 11 regarding collective action:

- 12
 13 1. Physicians who take part in collective action are not exempt from their ethical or
 14 professional obligations to patients.
- 15 2. Even when the action taken is not organized by or associated with the Constituent Member,
 16 the Constituent Member should ensure that the individual physician is aware of and abides
 17 by their ethical obligations.
- 18 3. Whenever possible, physicians should press for reforms through non-violent public
 19 demonstrations, lobbying and publicity or informational campaigns, and/or through
 20 negotiation or mediation.
- 21 4. If involved in collective action, Constituent Members should act to minimize the harm to
 22 the public and ensure that essential and emergency health services, and the continuity of
 23 care, are provided throughout a strike. Further, Constituent Members should advocate for
 24 measures to review exceptional cases. If involved in collective action, Constituent
 25 Members should provide continuous and up-to-date information to their patients and the
 26 general public with regard to the demands of the conflict and the actions being undertaken.
 27 The general public must be kept informed in a timely manner about any strike actions and
 28 the restrictions they may have on healthcare.¹³

29 30 ETHICS ISSUE

31
 32 What are the ethical considerations regarding participation in collective labor action by physicians?
 33 Since certain collective actions can be disruptive, they present a potential risk to patient care and
 34 thus create a dilemma for physicians, particularly when collective actions may create immediate
 35 risks to patients, even if intended as a means to improve patient care in the long term. What
 36 collective actions by physicians are ethically permissible must be examined to ensure that the
 37 primacy and quality of patient care are protected. The core ethical issue is whether physicians who
 38 embrace tactics used by organized labor will also still be able to embrace their role as
 39 professionals.

40 41 REVIEW OF RELEVANT LITERATURE

42
 43 While not all collective actions by physicians may impact clinical practice, disruptive actions such
 44 as strikes result in practical challenges to clinical care. This report defines a disruptive collective
 45 action by physicians as any collective action that disrupts the day-to-day workflow of physicians
 46 within the healthcare systems in which they practice. Some of these actions may have the potential
 47 to decrease quality of care and cause patient harm.

48
 49 The normative ethics literature on the use of collective actions by physicians is generally cautious
 50 about collective actions that present a risk to patients, such as striking. A common stance is that,
 51 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.^{6,13,14,15,16} 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.^{6,14}

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 recognize physicians as laborers with all the rights of laborers, while protecting 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 deprofessionalization 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 healthcare, 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 healthcare 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.^{6,15} 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.^{6,15,17}

Others have held that strikes by physicians are almost never justifiable.¹⁸⁻²⁰ 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, the use of such means as strikes or slowdowns 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 profession of medicine has thus been compromised by physicians themselves. Those who

choose to pursue their self-interest, as union members might, cannot at the same time demand a superior moral position in society.¹⁸

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 and 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,²¹⁻²⁴ much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.^{22,23} 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.²¹ Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the U.K., 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.²⁴ 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 healthcare institutions. Reports of strongly negative public perceptions during a recent physicians’ strike in South Korea, while not systematic, suggest a note of caution.²⁵

ETHICS 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 healthcare sector has seen an increase in the complexity of healthcare systems, the transition to a majority physician employment

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

6
7 The result is a general loss of control over practice conditions that has driven dissatisfaction,
8 burnout, and early retirement from the profession. However, the issue is not necessarily
9 employment itself, but the associated loss of independence of clinical practice and control over the
10 clinical environment, which many today see as the deprofessionalization of medicine.

11
12 For those seeking to maintain and restore physician authority and independence, the primary
13 avenue has been to pursue legal and political actions, such as lobbying (either independently or
14 through medical associations). However, with the shift towards physician employment, physicians
15 are now considering the use of tools that laborers have historically relied on for negotiating, such as
16 legally permissible collective actions, in their attempts to improve patient care. This acceptance of
17 the tools of organized labor, however, is in tension with medicine's self-understanding and public
18 representation of itself as a profession with distinct privileges granted by society in recognition of
19 its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are
20 not likely to violate the norms of medical professionalism.²⁶ Disruptive collective actions, however,
21 which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care,
22 and cause harm to patients, seem *prima facie* to violate the medical profession's fundamental duty
23 to do no harm and care for patients. Any disruptive collective action that causes harm to patients is
24 inherently inconsistent with the responsibilities and duties of physicians.

25
26 Disruptive collective actions that create the potential for harm to patients, even minimally, and
27 even if undertaken for the purpose of improving the care of other patients in the future, are
28 therefore to be avoided. This does not mean, however, that all forms of disruptive collective action
29 must be avoided. Certain forms of disruptive action, such as collective refusal to comply with
30 administrative directives that are understood as antithetical to good patient care or otherwise
31 incompatible with the norms of professional ethics, may be ethically justified. Other forms of
32 disruptive action that are aimed at disrupting administrative processes such as billing but do not
33 disrupt service to patients might also be justified. Disruptive actions should only be undertaken,
34 however, as a last resort when good faith negotiations have broken down and the aim of the action
35 is to improve patient care.

36 37 CONCLUSION

38
39 Physicians must uphold their central ethical and professional responsibilities to patients when
40 considering collective actions. When considering disruptive collective actions, physicians should
41 take into account that the care of current patients must be continued and not compromised; urgent,
42 emergent, and otherwise needed medical care must still be provided; and all other non-disruptive
43 actions that do not negatively impact patients must first be exhausted. Additionally, the primary
44 goal of the action must be to improve patient care and not solely physician self-interest. To protect
45 the integrity of the profession, patients and the public should also be informed well in advance and
46 be continuously updated with respect to the demands being made and the actions being undertaken,
47 with the terms for resolving disruptive actions made public and open to scrutiny and discussion.
48 Whether all these conditions can ever be met in a physician strike or work slowdown remains an
49 open question.

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

RECOMMENDATION

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

1. That Opinion 1.2.10 be amended by addition and deletion with a change in title to read 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 well-being 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 well-being, 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 well-being.

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 well-being.
- (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~~

- 1 conditions, health and well-being, and/or institutional culture that negatively affect patient
2 care:
3
4 (i) physicians should refrain from collective action that would likely jeopardize the health
5 of patients or compromise patient care;
6
7 (ii) physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of
8 collective action that do not compromise patient care, with the primary objective to
9 improve patient care and outcomes by calling attention to and/or making needed
10 changes in practices, protocols, incentives, expectations, structures, and/or institutional
11 culture; and
12
13 (iii) physicians should avoid disruptive collective actions that would predictably and
14 directly compromise patient care, including strikes, due to their potential to undermine
15 physicians' primary duty to patient welfare, and should not use such actions primarily
16 for physician self-interest.
17
18 (c) Physicians should avoid forming workplace or other alliances, such as unions, with
19 ~~workers~~ colleagues and others who do not share physicians' primary and overriding
20 commitment to patients.
21
22 (d) Physicians should refrain from using ~~undue influence or pressure~~ colleagues ~~punitive or~~
23 ~~coercive means to force others~~ to participate in advocacy activities or collective actions, or
24 to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to
25 participate in such activities. (Modify AMA Policy)
26
27 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind
28 AMA Policy)

Fiscal Note: Minimal

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REPORT 05 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Care of Patients in Legal Custody

EXECUTIVE SUMMARY

Policy D-345.970, “Carceral Systems and Practices in Behavioral Health Emergency Care,” was adopted at the 2025 Annual Meeting. Its third directive asks the Council on Ethical and Judicial Affairs: “to study this topic to provide clearer guidance for healthcare professionals regarding interacting with law enforcement while caring for patients and the shackling of youth and adults in carceral custody, with particular attention to the removal of shackles.”

This report examines the ethical challenges involved in caring for patients in legal custody, with attention to the practical constraints faced by both patients and their physicians. The Council identifies ethics issues beyond the scope of shackling and offers recommendations on a wide range of concerns, including conflicts of interest and dual loyalties, decisional autonomy, informed consent, surrogate decision-making, privacy, confidentiality, shackling, continuity of care, reporting abuse, improving policies, and working alongside custodial staff. The report emphasizes that patients in legal custody retain the same ethical rights as all other patients regardless of custodial status.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-I-26

Subject: Care of Patients in Legal Custody

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

[Policy D-345.970](#), “Carceral Systems and Practices in Behavioral Health Emergency Care,” was adopted at the 2025 Annual Meeting. The third directive asks the following:

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

This report provides ethics analysis and ethics policy recommendations regarding the treatment of patients in legal custody, including but not limited to the use of shackles.

BACKGROUND

The United States has approximately 2.3 million incarcerated people,¹ a population that also faces healthcare disparities.² The U.S. prison population has rapidly increased over the last 50 years, rising from 300,000 people in the early 1970s to well over 2 million people today.³ In 2016, the United States possessed 21 percent of the world’s prisoners while only accounting for about 4 percent of the world’s population,¹ making the U.S. a world leader in incarceration, both per capita and in total.⁴ Additionally, there was a record high of individuals in immigration detention in January 2026, numbering over 70,000 people, 74 percent of whom have no criminal convictions.⁵ In this report, people in legal custody are considered broadly and include anyone in prison (state or federal), jail, immigration detention centers, or held as prisoners of war. All people in legal custody should be considered patients in custody, because, as wards of the state, their health is overseen by the state as are all medical issues—whether preventive, acute, or emergent.⁶

In the U.S. context, prisons have played a role in an unjust legacy of slavery and racial discrimination. After the Civil War, the criminal justice system became “central to new strategies of racial control.”³ Any analysis of the U.S. carceral system should reflect and consider this historic and political reality. The legacy of racial discrimination and institutional control not only amplifies disparities in healthcare for people in legal custody, but also informs specific practices such as shackling, where security and safety measures often overshadow professional assessment and ethical patient care. Although shackling is intended for safety and may not be used as a method of punishing an inmate,⁷ the common use of shackles reflects a broader history rooted in control and punishment. Ongoing work by the American Medical Association (AMA) addresses the ethical

* 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.

implications of practices such as shackling and highlights the need for comprehensive guidance on physicians' responsibilities to all patients in custody.

The AMA's Council on Science and Public Health (CSAPH) presented a report at Annual 2025 covering current protocols for shackling patients in legal custody, the arguments made in support of shackling, and current reforms to ban or limit universal shackling of patients in legal custody.⁸ The report found that while incarcerated individuals experience significantly worse physical and mental health than the general population, correctional systems generally lack adequate health infrastructure, often requiring that patients be transferred to external healthcare institutions.⁸ Patients in legal custody are often shackled through the entirety of their stay at these external healthcare institutions without consideration of individualized risk assessments, and hospital staff rarely intervene to request the removal of shackles. The CSAPH report calls for shackling policies to mirror restraint standards, clear procedures for clinicians on how to communicate with correctional officers, and defined circumstances regarding when shackling is not necessary or should be prohibited.⁸ While the CSAPH report addresses issues specific to shackling, there remains a need for comprehensive guidance on the broader ethical responsibilities of physicians caring for patients in legal custody.

ETHICS ISSUES

Patients in legal custody face a loss of physical liberty and other systemic constraints, which often make upholding physicians' ethical obligations challenging and reduce trust in the patient-physician relationship.⁸ Physicians treating patients in legal custody also may face conflicts of dual loyalties and inconsistent or absent institutional practical guidelines and may feel unsure about how to best support safety and security. Such situations can also create barriers to privacy and confidentiality, autonomy in medical decision-making, access to care (including choosing a health care professional or receiving timely and/or quality care), and informed consent and create greater risk of physical and mental harm. While patients in legal custody do face inequities, patients in legal custody retain the ethical right to high-quality healthcare as do all other patients, and the comprehensive ethics guidelines outlined in the AMA *Code of Medical Ethics* still apply to this patient population.

REVIEW OF RELEVANT LAWS & POLICY

Relevant Laws

An overview of the legal landscape reflects the minimum standards society has codified for patients in legal custody. The constitutional foundation for the healthcare of patients in legal custody derives from the Eighth Amendment,⁹ which prohibits cruel and unusual punishment. In *Estelle v. Gamble* (1976), the Supreme Court held that deliberate indifference to the serious medical needs of incarcerated individuals is unconstitutional, establishing a state duty to provide medical care.¹⁰ In *Brown v. Plata* (2011), the Court confirmed that institutional conditions, such as overcrowding leading to inadequate care, are equally impermissible.¹¹

Pretrial detainees are protected under the Fourteenth Amendment's Due Process Clause,¹² as established in *Kingsley v. Hendrickson* (2015),¹³ while individuals in immigration detention are covered under the Fifth Amendment's Due Process Clause,¹⁴ as established in *Zadvydas v. Davis* (2001).¹⁵ Regardless of the relevant constitutional provision, the underlying obligation is consistent: the state must provide adequate medical care to those in its custody.

Patients in legal custody also retain fundamental rights to bodily autonomy, informed consent, and decision-making, including the refusal of life-sustaining interventions.¹⁶ *Washington v. Harper* (1990) affirmed the right to refuse treatment; however, at the discretion of a prison's internal review board, patients in custody can be medicated against their will if they have a mental disorder and are deemed dangerous to themselves or others.¹⁷ *Cruzan v. Director, Missouri Department of Health* (1990) established that incarceration does not eliminate informed consent requirements.¹⁸ *Riggins v. Nevada* (1992) and *Sell v. United States* (2003) established that forced psychiatric medication must be medically appropriate, necessary, and the least restrictive option available.^{19,20}

For patients in legal custody who lose the capacity to make medical decisions, a legally authorized healthcare representative should serve as a surrogate decision-maker in accordance with state law. Few states explicitly address custodial status in surrogate decision-making statutes, and correctional staff rarely have legal authority to make medical decisions on behalf of incapacitated patients.¹⁶ As of 2022, 12 jurisdictions explicitly prohibit correctional officials from serving as surrogates for incarcerated patients who lack decisional capacity.^{21,22} Four states explicitly authorize correctional staff to make medical-decisions for unrepresented incarcerated patients.²³

The Emergency Medical Treatment & Labor Act (EMTALA) protects any individual presenting to a Medicare-participating emergency department, and law enforcement cannot remove a patient before they are medically stable.²⁴ The Americans with Disabilities Act (ADA) and Rehabilitation Act require equal access to care and reasonable accommodations across all facility types.²⁵ The Health Insurance Portability and Accountability Act (HIPAA) legally protects patient privacy in custodial settings, permitting only minimum necessary disclosures related to safety and custody coordination.²⁶

Federal law provides additional protection for certain populations. The First Step Act (2018) prohibits, with limited exceptions, the use of physical restraints on pregnant individuals in federal custody during labor, delivery, and postpartum recovery.²⁷ Forty-two states and Washington D.C. have enacted similar restrictions as of 2025.²⁸ For youth, the Juvenile Justice and Delinquency Prevention Act establishes baseline care standards,²⁹ and, while not illegal, courts have increasingly condemned routine shackling of minors in any setting as unconstitutional.

Taken together, these standards establish that patients in legal custody have the legal right to healthcare as well as other protected rights equal to any other patient. The law does not create a separate standard of care for this population; instead, it reaffirms the same principles of adequate care, informed consent, bodily autonomy, and non-discrimination that govern the broader practice of medicine.

Relevant AMA Policy

The *Code of Medical Ethics* [Opinion 1.1.3](#), "Patient Rights," and [Principles I and IX](#) make it clear that patients in all clinical scenarios, including those in legal custody, should be treated equitably and with respect for their human dignity. When patients or populations are discriminated against, treated unjustly, or receive less than adequate healthcare, physicians are ethically obligated to advocate for change, address barriers to equitable care, and protect the most vulnerable patients and populations as outlined in [Opinion 1.1.2](#), "Prospective Patients"; [Opinion 11.1.1](#), "Defining Basic Health Care"; [Opinion 11.1.4](#), "Financial Barriers to Health Care Access"; [Opinion 11.2.1](#), "Professionalism in Health Care Systems"; and [Opinion 11.2.7](#), "Responsibilities to Promote Equitable Care."

House Policy [H-430.986](#), “Health Care While Incarcerated,” advocates for healthcare rights and support of patients before, during, and after incarceration. The AMA supports patients in custody and advocates for quality healthcare, adequate physician financial compensation, security of health insurance, reduced co-pay, health literacy training, staff training, and institutional oversight. Additionally, the AMA is represented on the Board of Representatives for and supports the standards outlined by the National Commission on Correctional Health Care.³⁰

[Opinion 1.2.7](#), “Use of Restraints,” is also clear that all individuals have a right to be free from unreasonable bodily restraint. It provides guidelines that restraints should be used only when necessary to prevent harm, applied in the least restrictive manner, and removed promptly when no longer needed. However, shackles used in custodial situations differ from clinical restraints in that shackles are used for security purposes and controlled by correctional authorities, while clinical restraints are used to protect the patient and staff from harm and are only clinical in their purpose. The AMA has one policy explicit to the practice of shackling. [House Policy H-420.957](#), “Shackling of Pregnant Patients in Labor,” supports only using the least restrictive restraints when they are necessary for patients in the 2nd or 3rd trimester of pregnancy and holds a high bar for necessitating restraints on an inmate in labor, in delivery, or recuperating postdelivery.

Overall, the use of shackles lacks medical ethical oversight; however, physicians are still ethically obligated to protect patient dignity and safety, including by advocating against the use of shackles when they cause harm or interfere with medical care while respecting their potential necessity to maintain safety. Physicians have an ethical obligation to respect patient rights as outlined in [Opinion 8.5](#), “Disparities in Health Care,” and [Opinion 1.2.7](#), “Use of Restraints,” including by providing respectful, dignifying care and avoiding discrimination in the care they provide.

In addition to issues that arise due to loss of physical liberty, physicians caring for patients in legal custody often face dual loyalties resulting in ethical dilemmas, conflicts of interest, and potential harm to patients. Upon entering a contract to deliver healthcare, physicians maintain the obligation to put the welfare of patients ahead of other considerations and ensure their contract does not restrict care or prevent them from upholding their ethical and professional obligations as addressed in [Opinion 11.2.2](#), “Conflicts of Interest in Patient Care”; [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services”; [Opinion 1.2.6](#), “Work-Related & Independent Medical Examinations”; and [Opinion 11.2.1](#), “Professionalism in Health Care Systems.” Regardless of dual loyalties, physicians should put the care of their patients first ([Opinion 11.1.1](#)).

Dual loyalties to the state may also arise through court-initiated medical treatments in which physicians are ordered to provide specific treatments to patients in legal custody. [Opinion 9.7.2](#), “Court-Initiated Medical Treatment in Criminal Cases,” outlines a framework for using professional judgment to determine the efficacy and ethicality of a mandated treatment and reinforces the necessity of obtaining voluntary informed consent before initiating treatment. [Opinion 2.1.1](#), “Informed Consent,” outlines the ethical and legal process of informed consent, which is essential for upholding trust and independent, voluntary decisions within the patient-physician relationship. Physicians have the ethical obligation to uphold informed consent for all patients or their surrogate if the patient lacks decision-making capacity, including those in legal custody.

Beyond individual physicians’ ethical responsibilities to vulnerable populations, including those in legal custody, healthcare and custodial institutions and systems have ethical obligations to uphold the health and safety of people in legal custody as well. Healthcare organizations and physician employers must recognize patients as the primary obligation of physicians by enabling them to respond to the unique needs of individual patients and providing avenues for meaningful appeal

and advocacy on behalf of patients ([Opinion 11.2.1](#)). Additionally, [Opinion 11.2.7](#), “Responsibilities to Promote Equitable Care,” states that healthcare organizations should “change institutional policies and practices that may perpetuate or create barriers to equitable care,” and work “to minimize conditions of living that contribute to adverse health status” within the community. This includes advocating for changes to custodial systems that negatively impact patients’ health.

ETHICS ANALYSIS

Physicians have an ethical obligation to provide quality care and uphold patients’ ethical rights, including informed consent; timely, high-quality, and responsive care; dignity; privacy; confidentiality; and autonomy in making healthcare decisions. Patients in legal custody, however, face a distinct set of circumstances that creates conditions whereby established ethical standards are regularly compromised, including, but not limited to, loss of autonomy, loss of physical liberty, and inadequate institutional protections. The following analysis examines these challenges through the lens of the *AMA Code of Medical Ethics*.

Loss of Physical Liberty

Patients in legal custody face a loss of autonomy and agency from their confinement, surveillance, and custody under the state. Custody status impacts not just one’s access to care, but the quality and timing of that care. Patients in custody report a lack of available services, including specialty care and mental health services, as well as care that is compassionate and trauma informed.³¹ They also face poor quality care due to bias and discrimination.^{31,32,33} For example, the condition of solitary confinement, which has been recognized as cruel, inhumane, and a form of torture by the United Nations Human Rights Committee,³⁴ not only exacerbates existing health conditions, but also increases the likelihood of receiving no or delayed care.³⁵ Those specifically held in immigration detention, such as Immigration and Customs Enforcement (ICE), Customs and Border Patrol (CBP), and the Office of Refugee Resettlement (ORR), often face conditions that fail to uphold the health and dignity of migrants or even provide basic services at all.³⁶ While many barriers to accessing adequate healthcare may stem from institutional policies, the *Code* outlines physicians’ and organizations’ responsibilities to promote change as well as physicians’ ethical obligations to provide timely and quality care in [Opinion 11.2.7](#), “Responsibilities to Promote Equitable Care”; [Opinion 11.2.1](#), “Professionalism in Health Care Systems”; [Opinion 1.1.6](#), “Quality”; and [Opinion 1.1.3](#), “Patient Rights.”

For patients in legal custody who are able to access and receive care, the physical design of healthcare facilities can directly affect their autonomy, privacy, and dignity. Buildings designed to accommodate necessary security needs—for example, with secure treatment areas, separate entrances or units, or doors and windows that allow custody staff to maintain line of sight from outside the room—may reduce reliance on more disruptive or harmful measures, such as shackling or the presence of custody staff during private clinical encounters.³⁷ This raises an important justice concern, because not all healthcare settings are built to balance security needs with patients’ rights. Within those environmental limitations, physicians should still work with custody staff to protect each patient’s dignity, privacy, confidentiality, and access to appropriate care.

A common safety procedure for patients in legal custody that can impact autonomy and the provision of care is the practice of shackling during transport and throughout medical encounters. The use of shackles can contribute to poor quality care and illicit harm, create a coercive environment, and ultimately reduce patient autonomy, privacy, confidentiality, and trust. Shackling may interfere with medical care, including diagnostic evaluation, physical examination, or mobility

1 for rehabilitation.³⁸ It is also associated with exacerbation of trauma, stigmatization, and decreased
2 trust in health systems and the patient-physician relationship.³⁹ Moreover, the presence of shackles,
3 compounded by discrimination, may impact how physicians perceive incarcerated patients, thus
4 reducing empathy, increasing diagnostic skepticism, and heightening fear of personal harm.^{40,41}
5 Beyond physical and psychological consequences, shackling may also compromise informed
6 consent, as shackling can contribute to negative physician bias and patients may be unable or
7 unwilling to ask questions, express concerns, or refuse care when physically restrained or in the
8 presence of custodial staff.⁴²

9
10 Not all hospitals have policies and communication protocols regarding shackling despite the known
11 risks of its use, and there is a common misconception among physicians that they cannot influence
12 custodial staff's routine use of shackles. However, [Opinion 1.1.1](#), "Patient-Physician
13 Relationships," states that physicians have an ethical obligation to advocate for their patients'
14 welfare. Recognizing the influence physicians have is a critical step toward advocating for the
15 safety and dignity of patients. Importantly, advocacy does not always equate to requesting the
16 removal of shackles; rather, it involves carefully assessing each situation and collaborating with
17 custodial staff to balance patient safety, dignity, and clinical needs. This collaboration can help
18 make safety practices such as routine shackling more individualized and reduce harm.³⁷ While
19 literature remains limited, one study from 2022 found that only 37 percent of physicians and 33
20 percent of nurses requested the removal of their patients' shackles during their clinical encounter.⁴¹
21 Established ethics review committees, outlined in [Opinion 10.7](#), "Ethics Committees in Health
22 Care Institutions, and [Opinion 10.7.1](#), "Ethics Consultations," offer a structured option for
23 physicians to advocate for their patients when disagreements arise and are frequently suggested as
24 a practical tool for working alongside custodial staff.^{43,44}

25
26 One model demonstrating how ethical shackling can be operationalized in practice comes from
27 Boston Medical Center (BMC). BMC has pioneered its "Recurring Shackle Assessment" process,
28 which utilizes the electronic health record (EHR) and physician communication with the
29 correctional health team.³⁹ The model parallels standard hospital evaluations of patients restrained
30 for medical or behavioral reasons, making shackling review a part of routine clinical care.³⁹ If
31 criteria for removing shackles are met, the medical team escalates the request through structured
32 communication with the correctional health team.³⁹ By formalizing documentation, creating a
33 shared-decision framework, and building accountability through the EHR, BMC's model reduces
34 the unnecessary use and harm of shackles. Ethically, this procedural innovation demonstrates how
35 a clinical workflow can operationalize principles of beneficence and nonmaleficence while
36 respecting patient dignity. Although designed as an institutional protocol, such an approach could
37 be adopted more broadly by health systems or mandated by professional ethics bodies, illustrating
38 how procedural safeguards can serve as enforceable solutions to ethical violations in custodial
39 healthcare.

40
41 Other key ethical concerns that often arise in caring for this patient population involve privacy,
42 confidentiality, and informed consent.⁴⁵ Legal and physical limits on the right to privacy can
43 interfere with medical ethics obligations to uphold patient privacy and confidentiality, often with
44 ramifications for the patient-physician relationship and the provision of quality care. [Opinion 3.1.1](#),
45 "Privacy in Health Care," addresses privacy as fundamental for respecting patient autonomy and
46 upholding trust. While the *Code* provides ethical guidance on maintaining trust with the presence
47 of outside observers, the presence of custodial staff poses unique challenges ([Opinion 3.1.2](#)).
48 Unlike typical outside observers, custodial staff are present to enforce security measures, and their
49 presence may not be optional. Therefore, physicians should use discretion and balance obligations
50 to patient privacy and confidentiality with legally mandated security protocols when advocating for
51 patients in legal custody.

Informed consent is crucial to shared decision-making and to upholding patients' right to receive information, ask questions about treatments, and make informed, voluntary decisions about their healthcare ([Opinion 2.1.1](#)). Additionally, the American College of Correctional Physicians lists "Justified treatment & informed consent" and "The right to refuse care" as key principles for caring for incarcerated patients,⁴⁶ requiring that physicians respect patients' right to make their own medical treatment decisions and optimize the ability of patients to provide informed consent, including for treatments at the end of life.

Physician Dual Loyalty Conflicts

Physicians caring for patients in legal custody, especially those working within custodial settings, may face a conflict of dual loyalty, such that their primary obligation to the patient's welfare is challenged by pressures from an employer, institution, or state, which often arise from the necessity to balance patient care with safety and security. Physicians working outside of custodial settings may be challenged by similar pressures and may fail to mitigate perceptions of dual loyalty. While physicians should respect the obligations of custodial staff to prevent patient elopement and ensure a safe environment, collaboration with custodial staff should not compromise the physician's independent clinical judgment.

Many physicians work in custodial settings under contract with government agencies, private companies, or correctional institutions. This contractual employment structure can exacerbate dual loyalty conflicts by tying physicians to institutional priorities over patient care. Contracts may pressure physicians directly or implicitly to compromise patient care in favor of reducing costs, limiting advocacy, or avoiding reporting institutional abuses. Resource limitations, including restricted staffing, short appointment times, or limited access to specialty care, can reduce both physician and patient autonomy.⁴⁷ Additionally, physicians may be asked to perform evaluations for parole, fitness for duty, or legal compliance, creating further tension between the patient's best interests and institutional or legal requirements, potentially leading to moral distress for physicians.⁴⁷

The *Code* directly addresses the ethical implications of such arrangements. [Opinion 11.2.3](#), "Contracts to Deliver Health Care Services," emphasizes that contracts with institutions or employers should not interfere with physicians' independent medical judgment, nor should they restrict their ability to provide clinically appropriate care or to advocate for the needs of their patients. Despite clear ethics guidelines, pressure to stay loyal to employers and to not risk facing blowback or negative consequences from reporting abuse remains prevalent. While medical professionals have a duty to report abuse in the best interests of patients, such as any potentially inappropriate use of shackles during labor and delivery, such violations continue to occur even in states with legislative bans.⁴⁷⁻⁴⁹ An expose in New York prisons demonstrated how, between 2010 and 2024, researchers identified 61 allegations of prison medical staff "concealing evidence of guards' abuse, usually by forgoing examinations or not documenting injuries."⁵¹

A common example of a conflict of interest that may lead to improper care is the involvement of custodial staff in medical decision-making, even when patients retain medical decision-making capacity.⁵² Patients in legal custody maintain the right to make their own healthcare decisions and appoint a surrogate decision-maker in the event of future incapacity; however, physicians often lack awareness of this legal and ethical right.¹⁶ It is not uncommon in clinical settings for physicians to mistakenly default to custodial staff instead of the patient for medical decision-making.⁵³ When a patient in custody lacks decisional capacity and has not previously designated a surrogate, or the patient in legal custody is a minor and their parent or legal guardian is not accessible, the legal standard for surrogate decision-making that applies to other patients in that

jurisdiction should be followed. In the case a surrogate cannot be identified, it is ethically necessary to obtain a court-appointed surrogate rather than defaulting to custodial staff in order to ensure that the patient's best interests are protected and decision-making is made by someone free from conflicting loyalties to custodial authorities and who is not inappropriately influenced by the patient's custodial status.

Additional Impacts of Institutional Oversight

Patients who are in legal custody are afforded the right to basic healthcare by federal law; however, governmental guidance and practical policies are incomplete or inconsistently implemented, contributing to ethical pitfalls in the care of patients in legal custody. The *Code*, however, holds physicians, healthcare organizations, and physician employers accountable for advocating for changes to promote high-quality care for all patients ([Opinion 11.2.1](#), [Opinion 11.2.7](#)). Federal and state policies should be developed to support physicians in their ethical and professional obligation to prioritize patient care as well as recognize the unique challenges and potential areas of confusion physicians face when caring for patients in legal custody. Institutions should also develop policies and guidelines that recognize barriers that lead to differences in care and health outcomes for people in legal custody, including restrictions on autonomy and dual loyalty conflicts, and provide physicians with actionable steps to overcome those barriers rather than ignore or accept them.⁵⁴

In 2025, the U.S. Secretary of Homeland Security rescinded guidelines limiting ICE enforcement in hospitals,⁵⁵ thus increasing the interactions of hospital employees with immigration officers. While hospitals are directed to train staff, guidelines are fragmented, often provide conflicting advice, and perpetuate ethical violations relating to patient care, including failures to provide continuity of care or proper discharging of patients, the ethical obligations outlined in [Opinion 1.1.5](#), "Terminating a Patient-Physician Relationship."⁵⁶ This lack of institutional organization perpetuates confusion among physicians despite the *Code*'s existing ethics guidance. The BMC Recurring Shackle Assessment embedded in the EHR is one example of a policy supporting physicians' advocacy for patients and demonstrates that effective policies can reduce ethical violations.

Financial factors also arise as a barrier to care.⁴⁸ While more recent studies are lacking, as of 2016, the rate of patients who were incarcerated that received medical care for an existing health problem was significantly less within facilities charging co-payments for medical visits.⁵⁷ The National Commission on Correctional Health Care (NCCHC) is opposed to fees or co-pays that may restrict people's access to healthcare,⁵⁸ and the AMA encourages physicians to be mindful when "arrangements have the potential to put patients' interests at risk" ([Opinion 11.2.3](#)) and guides physicians and organizations to advocate for policy changes when patient access to care is restricted ([Opinion 11.2.7](#)).

Additionally, visitation policies vary wildly and often act as an impediment to surrogate decision-making, despite patients in custody's legal right to an advance directive and a surrogate if they lack decisional capacity.⁵⁹ When patients in legal custody lack decisional capacity, physicians often express uncertainty regarding who the appropriate decision-maker should be and often give deference to prison authority.⁶⁰ However, custodial staff acting as a surrogate has natural liabilities, as the staff have conflicts of interests in pursuit of the state's interest, may not know patient preferences, or do not have the best interest of the patient at heart.^{21,61} Therefore, custodial staff should be treated as outside observers to medical treatment and should not be defaulted to as surrogate decision-makers. When patient health information must be disclosed to custodial staff, disclosure should be limited to the minimum amount necessary. Compromises to patient privacy

should be limited only to when there is an unmitigable threat to patients, physicians, or public safety that outweighs the harms of denying privacy and confidentiality.

CONCLUSION

Patients in legal custody face threats to their ethical rights due to external factors such as a loss of autonomy and the consequences of inherent dual loyalty conflicts faced by their physicians. Lacking or inconsistent institutional policies and guidelines often lead to undue harm from these external factors, such as impacts to respect, dignity, timely care, alternative care options, decisional autonomy, privacy, confidentiality, informed consent, and continuity of care. While the *Code* does not explicitly address the care of patients in legal custody, its opinions pertain to the care of all patients, including those in legal custody. Furthermore, the *Code* is clear that physicians and healthcare organizations, including custodial institutions, have ethical obligations to advocate for vulnerable populations and make policy changes to promote equitable care for all patients.

RECOMMENDATIONS

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

1. Patients in legal custody possess the same inherent human dignity and right to healthcare as all other patients. Regardless of custodial status, the formation of a patient-physician relationship obligates the physician to work to advance the good of the patient and to uphold respect for patients as persons. Physicians must approach patients in legal custody with a nonjudgmental regard and not allow invidious discrimination or assumptions about criminality to undermine their clinical judgment or the quality of care provided.

Patients in legal custody face unique circumstances that render them especially susceptible to harm and healthcare inequities. Understanding the historical, structural, institutional, and legal factors that contribute to their vulnerability provides essential insights that can assist physicians in upholding their ethical responsibilities and optimizing patient care. Confinement, surveillance, dependence on custodial officials, and loss of legal rights can disrupt access to healthcare services and challenge physicians' ability to uphold their ethical obligations to privacy, confidentiality, and the provision of safe, equitable care. Physicians must ensure the primacy of patient welfare and professional independence despite real or perceived conflicting loyalties to custodial authorities.

When caring for patients in legal custody, physicians should:

- (a) Provide care according to the same professional standards that apply to all patients, and work to identify and eliminate individual and systemic biases that threaten their care.
- (b) Mitigate real or perceived conflicts of interest and divided loyalties that may interfere with the delivery of equitable, high-quality care.
- (c) Respect their right to make their own medical treatment decisions and optimize the ability of patients to provide informed consent, including for treatments at the end of life. For patients lacking medical decision-making capacity, utilize a legally authorized surrogate decision-maker who is free from conflicting loyalties to custodial authorities and who will make medical treatment decisions based on ethically appropriate standards unless otherwise legally compelled.

- 1 (d) Uphold patient privacy and confidentiality to the greatest extent possible. Limit disclosures
2 of patient health information to custodial staff to the minimum amount necessary and
3 obtain patient consent to disclose when possible.
4
- 5 (e) Attempt to mitigate the harms of shackling or other custodial restraints when imposed by
6 custodial staff, and advocate for the least restrictive use of custodial restraints safely
7 possible, especially when they interfere with care delivery, with special attention to those
8 most vulnerable to harm.
9
- 10 (f) Strive to ensure safe disposition and continuity of care when patients are discharged or
11 return to custody.
12
- 13 (g) Support efforts within healthcare institutions to identify and improve policies and
14 procedures that create barriers to optimal care, establish mechanisms for documenting and
15 reporting abuse and neglect, and mitigate conflicts of interest and conflicting loyalties that
16 may threaten the physician's obligation to the primacy of patient welfare.
17
- 18 (h) Advocate with custodial staff and legal authorities to optimize patient access to high-
19 quality, equitable medical care, and advocate for change when patient care or the ethical
20 obligations of physicians are compromised by institutional policies and practices or
21 custodial staff actions that are beyond the physician's control.
22
- 23 (New HOD/CEJA Policy)
24
- 25 2. That the third directive of Policy D-345.970 be rescinded as it has been accomplished by this
26 report (Rescind AMA Policy)

Fiscal Note: Minimal

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REPORT 06 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Recording Clinical Encounters

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, Resolution 002, “Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters,” was referred. The Council on Ethical and Judicial Affairs has deemed it necessary to expand the scope of this report beyond just wearable recording devices and analyze issues relating to the use of multiple recording technologies during clinical encounters by both patients and physicians, with recommendations for new ethics policy as well as revisions to existing policy.

The use of recording technologies has the potential to benefit physicians and patients, but these benefits must be weighed against the associated risks. Recordings of clinical encounters should be made in a respectful and open manner that upholds the rights of all parties involved. Covert recordings (by either physician or patient) may endanger trust and hurt the patient-physician relationship if the situation is not carefully managed. Recording a clinical encounter by either patients or physicians necessitates that great care be taken not to cause harm to any party, which requires trust and transparency. Recording technologies also create the potential for unintended outside observers to be brought into clinical encounters. In order to support patients and uphold all parties’ ethical obligations, physicians should only use recording technologies for clinical purposes, and, while the *Code* does not speak to patients, patients should generally only use such technologies during clinical encounters for the purpose of improving their own well-being.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 06-I-26

Subject: Recording Clinical Encounters

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, Resolution 002, “Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters,” was referred. The resolution asks:

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

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)

Resolution 002 specifically cites AMA *Code of Medical Ethics* opinions [3.1.3](#), “Audio or Visual Recording Patients for Education in Health Care,” and [3.1.4](#), “Audio or Visual Recording of Patients for Public Education.” This report provides analysis of issues relating to the use of recording technologies during clinical encounters by both patients and physicians and offers recommendations for ethics policy.

BACKGROUND

Technological advances have made it increasingly easy to record information and to do so discreetly. The development of personal and wearable recording devices, from smartphones to glasses with recording capabilities, is driving societal and ethical controversy over their covert ability to record audio and video,¹ along with integrated AI technologies, such as facial recognition.²

In contrast to these technologies, there are also personal smart health devices that collect and track a wide variety of health data, such as movement trackers or data recorders of sleep, heart rate, blood pressure, or other types of physiological information.^{3,4} While these type of wearable devices track and record health data (and sometimes also use video to track data⁵), they are categorically

* 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.

different from audio-visual recording devices. In somewhat of a middle ground are ambient transcription tools, which can create written and audio records of conversations and which are becoming increasingly common tools for physicians to use during clinical encounters for note-taking purposes. Although there is some overlap of issues associated with audio-visual recording devices and wearable devices for tracking health data, such as concerns regarding privacy and data security,⁶ the key issues with health tracking devices are generally distinct from those associated with audio-visual recording devices. A primary area of concern for audio-visual recording centers on consent and disclosure.⁷

This report focuses primarily on personal audio-visual recording devices, especially those that can covertly record conversations or interactions between physicians and patients. In recent years, covert recordings with the use of wearable devices during clinical encounters have raised concerns and questions, both among patients and physicians. Incidents of recordings, given the ubiquitousness of the technology, are rising, performed by both patients and physicians,⁸ and are taking place both with and without permission.^{9,10} Covert recordings may endanger or negatively impact the patient-physician relationship, especially if a lack of dialogue leads to mistrust or fears of misuse.

Importantly, recording technologies can help improve the clinical experience by “recording care in the moment”¹¹ and offer useful applications in research, training, audits, quality improvement (QI) initiatives, streamlining consultations, and safety surveillance. However, these benefits are coupled with risks to patient privacy and data security, as rapid technological innovation raises questions about proper security protocols to protect patients, physicians, and data.¹¹

Relevant Legal Provisions

A notable legal concern associated with the use of wearable recordable devices in clinical encounters is the fact that the federal government and states may have different rules regarding consent to record conversations. The Electronic Communications Privacy Act¹² is a federal wiretapping law that “prohibits the interception and disclosure of wire, oral, or electronic communications without specific consent of at least 1 party.”¹³ Some states follow the federal “one-party” rule, while other states like California and Florida have adopted an “all-party” consent rule.¹³

Additionally, with regards to Health Insurance Portability and Accountability Act (HIPAA) compliance, whether the video is subject to HIPAA standards will depend on if it is created or received by a covered entity, like a physician. Notably, any recording made by a patient (and then not given to a physician) is not subject to HIPAA.⁹ This reflects an imbalance of protections and responsibilities between physician and patient, and presents an asymmetric legal risk that may engender distrust between them.¹⁰

Relevant AMA Policy Provisions

There are no House policies that directly address personal or wearable recording devices. However, there are a few related policies, which broadly support principles of patient privacy and confidentiality. Policy [H-315.983](#), “Patient Privacy and Confidentiality,” affirms our AMA’s commitment to upholding privacy and confidentiality, a stance reaffirmed in Policy [H-315.990](#), “Confidentiality of Computerized Patient Records.” Policy [H-480.943](#), “Integration of Mobile Health Applications and Devices into Practice,” outlines our AMA’s support of patient privacy specifically within the context of mobile health apps and associated devices, trackers, and sensors. Lastly, Policy 315.990 reaffirms the importance of confidentiality of patient records “regardless of

the form in which they are stored” and highlights the importance of “regulating third parties’ use of computerized patient records.”

Relevant Code Provisions

The *AMA Code of Medical Ethics* speaks broadly to the relevant issues of patient respect and autonomy, informed consent, safety, privacy, and confidentiality in multiple opinions, including: [Opinion 1.1.1](#), “Patient-Physician Relationships”; [Opinion 1.1.3](#), “Patient Rights”; [Opinion 1.1.6](#), “Quality”; [Opinion 2.1.1](#), “Informed Consent”; [Opinion 3.1.1](#), “Privacy in Health Care”; [Opinion 3.1.2](#), “Patient Privacy & Outside Observers to the Clinical Encounter”; and [Opinion 3.2.1](#), “Confidentiality.” Taken together, these opinions highlight the importance of upholding patients’ rights and ensuring that these rights are not violated if audio-visual recordings are made during clinical encounters.

Conversely, [Opinion 1.1.4](#), “Patient Responsibilities,” highlights patients’ ethical obligations and is a reminder that any recording done by patients should not interfere with their responsibilities to be truthful and forthcoming, be aware of and refrain from behavior that could jeopardize the health of others, and refrain from disruptive behavior. This includes refraining from making recordings with vindictive or malicious intent.

Additionally, there are two *Code* opinions that directly relate to audio and visual recordings of patients; however, these opinions only speak to the context of recording patients for educational purposes. [Opinion 3.1.3](#), “Audio or Visual Recording Patients for Education in Health Care,” speaks to audio and visual recordings as valuable tools for healthcare professionals but notes that physicians must balance educational goals with upholding patient privacy and confidentiality. Similarly, [Opinion 3.1.4](#), “Audio or Visual Recording of Patients for Public Education,” addresses how audio and visual recordings of patient care for public broadcast can help educate the public about healthcare, but states physicians also have an obligation to protect patient interests and ensure that professional standards are upheld. While the context for these opinions is not clinical care, both highlight the need to secure patient consent.

Despite the abundance of relevant ethics policy, there is no current opinion in the *Code* that directly addresses the use of personal recording devices by patients or physicians during clinical encounters.

ETHICS ISSUES

There exist several ethical issues associated with the use of recording technologies in clinical encounters, including patient autonomy, confidentiality, privacy, informed consent, safety, trust, and data security. Any type of recording (audio, visual, ambient, or transcription) may provide some record of a patient’s intimate details, which, if not properly stored or safeguarded, could substantially violate a patient’s privacy and could constitute a breach of confidentiality. However, such recordings can be valuable if they enhance clinical encounters, allow the physician to perform QI initiatives, or streamline medical recordkeeping. The recording of a clinical encounter by either patients or physicians necessitates that great care be taken not to cause harm to any party, which requires trust and transparency.¹⁴

Covert recordings (by either physician or patient) may endanger trust and hurt the patient-physician relationship if the situation is not carefully managed. Data on physician attitudes and responses to patient-initiated recordings are mixed, with some supportive but others finding that recordings may

inhibit discussion between the physician and patient.¹⁵ Experts now advise that physicians should “strive to treat every interaction with a patient as if it were being recorded and to carefully consider the complex ethical considerations at play” and approach recordings “with a more amicable orientation.”¹⁶

ETHICS ANALYSIS

It is important to emphasize that, ethically, video and audio recordings, including ambient transcriptions, produced by physicians or patients should only occur for clinical use, training (either for AI tools or other clinical staff), QI initiatives, research, education, or similar clinical purposes.¹⁷ If a recording is produced by a physician and it is not for clinically relevant purposes, such as for a physician’s personal use that is not medically related, then there exists no ethical basis for such recordings, even if patient consent is obtained. This is largely due to the inherent asymmetry of power in the patient-physician relationship and the potential for coercion, even if unintended. A potential exemption may be considered in cases of recordings for marketing purposes, though such instances must meet a high ethical barrier that includes far more than just obtaining informed consent and which must also adhere to the standards set out in *Code Opinion 9.6.1*, “Advertising & Publicity.” Conversely, patients should not record clinical encounters without disclosing their intent to do so, obtaining consent where legally required, and acting in compliance with all institutional patient policies, and should generally only record medical encounters with the intention of supporting their own well-being specifically in relation to their medical visit.

Recordings by Physicians

From the medical perspective, recordings during clinical encounters are ethically appropriate only if their potential benefits have first been fully weighed against potential disadvantages.¹⁸ While recording technologies offer clinical benefits, including for patient care, medical education, and QI initiatives, their adoption also presents complex ethical concerns regarding patient privacy, consent, data management and security, and resource allocation.¹⁹ To ameliorate these concerns, all recorded patient data must be HIPAA compliant and must be recorded only for clinical purposes. Patients should be reasonably informed about what will be recorded and the purposes of the recording. The use of any recording technology, including ambient listening tools, should be disclosed to patients, and informed consent should be obtained when necessary, such as when imaging sensitive areas.²⁰ Patients should be given the opportunity to decline the use of recording technology, and physicians should meaningfully engage with patients to answer any questions or concerns they may have regarding the use of such technology.²⁰

While it may be ethically permissible to use recordings of clinical encounters for advertising or publicity in certain circumstances, such instances should generally be discouraged. The use of recordings of clinical encounters for marketing creates risks to patient privacy and confidentiality, places undue pressure on informed consent due to the power differential in the relationship, creates the potential for an implied improper *quid pro quo* agreement, and in today’s social media environment creates the risk that such advertising becomes infotainment that diminishes the professional nature of the practice of medicine—all of which would not have otherwise occurred.^{21,22} In fact, prior to the Federal Trade Commission suing the AMA in 1975 over perceived restraint of trade, which forced the AMA to change its stance in the *Code*, the AMA had been unambiguous in its position since 1847 that advertising is the antithesis of professionalism and should be forbidden by physicians.^{23,24}

Recordings by Patients

While physicians are bound by professional ethics, patients are not held by the same professional obligations. Patients should generally only record clinical encounters in order to expressly support their well-being, such as to enable their review of verbal instructions and discussions related to their care or to assist with language barriers or learning difficulties, and not for retaliatory or other non-medically related purposes. Patients may wish to record a clinical encounter to help uphold accountability and protect against wrongdoing in support of their well-being but should not use such recordings in a coercive manner. Unfortunately, some patients may intend to surreptitiously record clinical encounters for malicious purposes; such actions violate patients' own responsibilities to refrain from disruptive behavior and be truthful and forthcoming with their physicians, which can severely damage trust and the patient-physician relationship.

If being recorded makes a physician uncomfortable, they should discuss this with the patient. If some form of understanding cannot be reached, the physician has the right to terminate the relationship consistent with *Code Opinion 1.1.5*, "Terminating a Patient-Physician Relationship." In such an instance, the physician must not immediately cease the provision of care and must facilitate the transfer of care and ensure that the patient has sufficient time to secure another physician before terminating the relationship.

In some circumstances, patients may wish to record their own clinical encounter as a means to share their experience and educate other patients. Similarly, some patients may wish to record their clinical experiences as a form of memento or a record of a personal journey, such as may occur during chemotherapy or during the birth of a child. Such instances generally constitute an appropriate and ethical use of recording technologies and may be broadly construed as part of patient well-being, though ethical procedures for recordings should still be upheld, such as ensuring other patients are not inadvertently recorded without their consent.

Before recording, patients should notify the physician of their intent to record, explain their reasoning for doing so, and ideally obtain consent from the physician to record the interaction in order to support clear communication and trust. However, patients do not always adhere to such practices, sometimes on purpose but also often out of ignorance. To support and protect physicians and facilitate trust and clear communication that underlie the patient-physician relationship, institutions can establish policies for the use of recording devices by patients and families, educate staff and volunteers about such policies, make information regarding such policies highly visible to patients, and provide written information regarding such policies to patients.²⁵

Responsibilities of Healthcare Institutions

In addition to establishing policies and procedures for the use of recording devices and educating patients and physicians about them, healthcare institutions also should ensure proper safeguards are in place related to data governance, stewardship, and security for recordings made by physicians in clinical settings. This can be particularly challenging when it comes to ambient scribe tools, as significant privacy risks are introduced by passively recording clinical encounters. These risks include the introduction of third-party vendors with potential access to audio and text data from encounters as well as increased targets for cyberattacks due to multi-vendor chains of data handling introduced by cloud-based data processing. In addition to local data, cybersecurity, and cross-border governance, healthcare institutions also face challenges due to uncertain and evolving regulatory frameworks for ambient transcription tools. Of note, the "ambient" terminology may also be misleading, obscuring the fact that data are not entirely passive, as they are often stored outside the institution's electronic health record. Ambient scribe technologies can also generate

multiple data artifacts far beyond finalized clinical notes, including raw audio recordings, conversation transcripts, draft outputs, prompts entered by users, and provenance logs, with governance of these data streams often unspecified or unclear to physicians.²⁶

The data collected from recording devices, especially those that collect a large volume of data such as ambient transcription tools, have been proposed as potentially useful for research; however, such practices would create ethical challenges. While there may be valuable research information that could be mined from such data, obtaining informed consent for unspecified purposes poses an ethical dilemma, as such broad or blanket consent policies fall short of true informed consent requirements for research. The involvement of third-party vendors also raises questions regarding who has access to and ownership of the data and for what purposes the data could be used. Though it may be possible to de-identify such data for QI initiatives or for health research that could fall under the ethically approved purpose of recordings used “for clinical care,” this would only be ethically permissible if patients are properly informed and consented in compliance with existing ethical standards. At present, such research practices likely infringe upon patients’ rights to autonomy, confidentiality, privacy, and informed consent and thus should be avoided.

CONCLUSION

The use of recording technology has the potential to benefit physicians and patients, but these benefits must be weighed against the associated risks. Recordings of clinical encounters should be made in a respectful and open manner that upholds the rights of all parties involved. Institutions have an ethical obligation to inform patients of their rights and responsibilities regarding the recording of clinical encounters, as well as to train physicians how and when to appropriately use such technologies themselves.

Recording technologies also create the potential for unintended outside observers to be brought into clinical encounters. Patients or physicians might post videos to online social media platforms, while device manufacturers might capture user data that potentially infringe upon patient privacy, especially as new technology makes de-identified data easier to re-identify, blurring traditional lines of who can be or should be considered an outside observer. In order to support patients and uphold all parties’ ethical obligations, physicians should only use recording technologies for clinical purposes, and patients should typically only use such technologies during clinical encounters for the purpose of improving their own well-being.

In general, physicians should remember to maintain professionalism in all patient interactions and that all conversations have the potential to be recorded. If a patient asks to record a clinical encounter, physicians should consider it a sign of patient engagement, ascertain the rationale for the recording to determine if it is ethically appropriate, and, if necessary, help to ensure that recordings do not capture other patients or staff without their express consent to uphold privacy and confidentiality. Institutions should develop policies and procedures for recordings by patients and should train physicians and other medical staff on how to respond to patients recording or making requests to record.²⁷

RECOMMENDATIONS

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

1. Recording technologies can help improve the clinical experience but also present risks to privacy, safety, security, and trust. Any type of recording (audio, visual, or transcription) of the

clinical encounter may provide some record of a patient's intimate details and, if made by or provided to a physician, constitutes a part of the medical record. The recording of a clinical encounter by either patient or physician necessitates that great care be taken not to cause undue harm to any party and requires transparency, communication, and trust. Covert recordings (by either physician or patient) endanger trust and harm the patient-physician relationship. Physicians should not record patients for non-medically relevant purposes, such as for a physician's personal use that is not medically related, even if patient consent might be obtained.

Conversely, physicians should help patients understand that they should not record clinical encounters without disclosing their intent to do so, obtaining consent where legally required, and acting in compliance with all legal and clinical regulations and should generally only record medical encounters with the intention of supporting their own well-being. If a patient asks to record a clinical encounter, physicians may inquire about the patient's intent and, if appropriate, help to ensure that recordings do not capture other patients or staff without their express consent to uphold privacy and confidentiality. If the physician suspects that a patient wishes to record a clinical encounter due to distrust, the physician should strive to find ways to build trust in the patient-physician relationship. In general, physicians should remember to maintain professionalism in all patient interactions and that all interactions have the potential to be recorded.

When recording clinical encounters, physicians should:

- (a) Inform the patient (or authorized decision maker) of the intent to record and:
 - (i) the purpose of the recording;
 - (ii) that any uses of the recording will be limited to those related to healthcare;
 - (iii) that they may withdraw consent to being recorded at any time, including during recording, and, if so, what will be done with the recording;
 - (iv) their right to access and request that information recorded be amended for accuracy as part of their medical record;
 - (v) assure the patient that their information will be treated as confidential health information and stored securely but acknowledge that no information can be perfectly secured.
- (b) Ensure that the patient has the opportunity to discuss any concerns about recording before, during, and after recording.
- (c) Obtain consent from the patient (or the authorized decision maker) prior to recording whenever possible.
- (d) In the case of minors, seek assent from the patient in addition to consent from the patient's parent or guardian.
- (e) Ensure recordings are securely stored and, when necessary, properly destroyed, in keeping with ethics guidance for managing medical records.

- (f) Engage openly with patients who wish to record their own clinical encounter. If the physician believes a patient recording compromises the patient-physician relationship, the physician may choose to terminate the relationship in keeping with ethics guidance.

To support patients and physicians, physician leaders in healthcare institutions should:

- (g) Create clear policies and procedures for the use of recording devices within their institutions by physicians.
- (h) Create clear policies and procedures for the use of recording devices within their institutions by patients and families.
- (i) Make information regarding such policies and procedures highly visible to patients and families, including by providing written information regarding such policies to patients.
- (j) Educate and train staff and volunteers about such policies and procedures.
- (k) Train physicians and other medical staff on how to respond to patients recording or making requests to record.
- (l) Advocate that patients only record clinical encounters in order to expressly support their well-being and not for retaliatory or other non-medically related purposes.
- (m) Advocate that before recording, patients notify the physician of their intent to do so, explain their reasoning for doing so, and obtain consent from the physician to record the interaction.
- (n) Minimize third-party exposure to patient care, including recordings and associated data. (New HOD/CEJA Policy)

2. That Opinion 3.1.2, "Patient Privacy & Outside Observers to the Clinical Encounter," be amended by addition and deletion as follows:

Individuals legitimately present during patient-physician encounters include those directly involved in the patient's care, and can include other members of the healthcare team or employees of pharmaceutical or medical device companies when they are present to provide technical assistance, in keeping with ethics guidance. However, recording technologies expand the notion of who counts as an outside observer by enabling third parties to access aspects of clinical encounters (including associated patient data) without being physically present at the time of a clinical encounter.

When individuals or entities who are not involved in providing care seek to observe patient-physician encounters, e.g., for educational, commercial, or governmental purposes, physicians should safeguard patient privacy by permitting such outside observers ~~to be present during access to~~ a clinical encounter only when:

- (a) The patient has explicitly agreed to ~~the presence of~~ grant the observer(s) access.
Outside observers or recordings should not be permitted when the patient lacks

1 decision-making capacity, except in rare circumstances and with the consent of the
2 parent, legal guardian, or authorized decision maker.

- 3
- 4 (b) ~~The presence of~~ Granting access to the observer, including access to recorded data, will
5 not compromise care.
- 6
- 7 (c) The observer understands and has agreed to adhere to standards of medical privacy and
8 confidentiality.
- 9

10 Under no circumstances should physicians accept payment from outside observers,
11 including vendors, to allow ~~those observers~~ them ~~to be present during~~ observe a clinical
12 encounter.

13

14 To support patients and physicians, healthcare institutions should:

- 15
- 16 (d) Ensure that granting access to third-party observers to clinical encounters, including
17 access to patient data, does not cause harm to patients or patient populations.
- 18
- 19 (e) Minimize third-party exposure to patient care, including recordings or any associated
20 patient data. (Modify HOD/CEJA Policy)
- 21

- 22 3. That Opinion 3.1.3, “Audio or Visual Recording Patients for Education in Health Care,” be
23 amended by deletion as follows:
- 24

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

31

32 To safeguard patient interests in the context of recording for purposes of educating
33 healthcare professionals, physicians should:

34

- 35 (a) Ensure that all nonclinical personnel present during recording understand and agree to
36 adhere to medical standards of privacy and confidentiality.
- 37
- 38 (b) Restrict participation to patients who have decision-making capacity. Recording should
39 not be permitted when the patient lacks decision-making capacity except in rare
40 circumstances and with the consent of the parent, legal guardian, or authorized
41 decision maker.
- 42
- 43 (c) Inform the patient (or authorized decision maker, in the rare circumstances when
44 recording is authorized for minors or patients who lack decision-making capacity).
45 (i) about the purpose of recording, the intended audience(s), and the expected
46 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 healthcare 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. (Modify HOD/CEJA Policy)

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 07-I-26

Subject: Physicians Are Not Providers

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2026 Annual Meeting, the House of Delegates (HOD) adopted [H-405.942](#), “Physicians are not Providers.” The fourth item of this policy states:

4. Our AMA refers the issue of “Physicians are not Providers” for possible consideration by the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA).

This report is submitted to the HOD in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician practice terminology.

BACKGROUND & ETHICS ISSUES

It is widely recognized that medicine is a learned profession, that the practice of medicine is a calling, not a trade. To describe medicine as such is to recognize the trust placed upon the profession, the corresponding rights granted by the public, and the associated ethical duties that physicians are accountable for and must uphold. Yet medicine as a profession has increasingly come under threat from commercial forces in recent decades that have driven trends in deprofessionalization. One such example is the use of the term *provider* to describe physicians and other healthcare professionals. The effect of this inaccurate terminology is not only harmful to medicine as a profession but also carries detrimental ethical consequences, as outlined in the July 2025 American College of Physicians position paper, “Physicians Are Not Providers: The Ethical Significance of Names in Health Care: A Policy Paper from the American College of Physicians.”¹

The use of the term *provider* is ethically problematic largely because it undermines professionalism and the corresponding ethical obligations. Its use creates confusion and misconceptions, as the term *provider* is often applied to a wide range of entities, including institutions, insurers, physicians, nurses, physician assistants, and other clinicians, thereby obscuring differences in clinical training, expertise, and obligations to patients. Of great concern is that the term creates the appearance of a transactional relationship, but patient-physician relationships are relational and built on trust; the patient is not merely a consumer but an autonomous individual who enters the relationship seeking care from a trained physician who is bound by ethical duties to help and who must act first and foremost in the patient’s best interest. Importantly, not only does the use of the term *provider* negatively impact patients’ and the public’s view of physicians and other healthcare professionals,

* 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.

but it can also negatively alter physicians' own sense of self, perceived professional value, and behavior.¹

RELEVANT POLICY & CODE OPINIONS

AMA Policy [H-405.968](#), "Clarification of the Term 'Provider' in Advertising, Contracts and Other Communications," states: "Our AMA [...] considers the generic terms 'health care providers' or 'providers' as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches." This policy is in alignment with the [Principles](#) outlined in the *AMA Code of Medical Ethics*, which clearly refers to the practice of medicine as a profession. This position is also outlined in the very first opinion in the *Code*, [Opinion 1.1.1](#), "Patient-Physician Relationships," which states: "The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship that emerges between a patient and a physician must be based on trust." This trust is fundamentally undermined by the use of the term *provider*.

ETHICS ANALYSIS & CONCLUSION

In ethics, words matter. The use of the term provider to refer to physicians and other healthcare professionals is not only inaccurate; it is ethically misleading and potentially dangerous. Existing House policy and ethics policy in the *Code* is clear: physicians are not providers and should not be referred to as such. In accordance with Policy [H-405.968](#), the term *provider* should not be used in lieu of *physician*.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the fourth item of Policy H-405.942, "Physicians are not Providers," be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-26)

Introduced by: Medical Student Section

Subject: Recognition of Intersex Individuals and their Human Rights

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, intersex individuals, also known as individuals with Differences of Sex Development
2 or “DSD” or Variations in Sex Characteristics or “VSC,” are those born with naturally occurring
3 variations in chromosomal, gonadal, or anatomical sex characteristics¹; and
4

5 Whereas, intersex is not synonymous with gender identities outside the male-female binary,
6 such as “non-binary” or “undesignated,” and individuals who are intersex may identify with any
7 gender, including man, woman, cisgender, or transgender²; and
8

9 Whereas, while intersex individuals may choose to self-determine their gender identity, they
10 should also have the right to identify as intersex as a distinct legal sex category, consistent with
11 precedent of intersex individuals seeking recognition of their intersex identities in legal sex
12 documentation outside of nonbinary gender markers³⁻⁵; and
13

14 Whereas, in January 2025, the President of the United States issued an executive order,
15 Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the
16 Federal Government, which erased the recognition of intersex individuals by asserting a sexual
17 binary defined by medically inaccurate terms⁶; and
18

19 Whereas, this legal and administrative oversight for intersex individuals reduces recognition of
20 their legitimate identity outside of the gender binary and increases the disparities experienced
21 by intersex people in all aspects of life, including healthcare, and violates their human rights^{7,8};
22 and
23

24 Whereas, the United Nations Committee against Torture recommends that legislative and
25 administrative procedures are in place to protect the recognition of intersex individuals and their
26 capacity to make decisions regarding their individual personal integrity and bodily autonomy⁹;
27 and
28

29 Whereas, the requirements and necessary documentation needed to obtain accurate
30 identification are inconsistent across different regions of the United States, often placing an
31 undue burden on intersex individuals seeking accurate identification¹⁰; and
32

33 Whereas, a study evaluating 1.5 million patient profiles from the Mass General Brigham Epic
34 EHR system revealed three sex and gender demographic fields comprising “Legal Sex”, “Sex
35 Assigned at Birth”, and “Gender Identity”, where the classification of “X” was restricted solely to
36 the “Legal Sex” field¹¹; and
37

38 Whereas, the use of multiple demographic and clinical data fields in electronic health records,
39 including legal sex, sex assigned at birth, and gender identity, has been shown to support more

accurate, patient-centered care than reliance on a single designation, thereby enabling inclusive identifiers such as “X” to coexist with safe and individualized medical decision-making¹²; and

Whereas, given the patchwork, bad-faith legislative landscape, as evidenced by the Kansas Senate Bill 244 and Louisiana House Bill 578, a binary definition of sex may compel the removal of “X” and other non-binary classifications in EHR databases^{13,14}; and

Whereas, the absence of an “Intersex”, “X”, or “DSD” designation in medical records may leave clinicians without critical and necessary “safety flags” or clinical decision support tools to bypass standard binary screening and care algorithms in favor of individualized care; therefore be it

RESOLVED, that the American Medical Association support the right of intersex individuals, including individuals with Differences of Sex Development (DSD) and variations in sexual characteristics (VSC), to have “intersex” or other inclusive alternatives, such as “X,” beyond the sex binary available as a sex designation at birth or selected later in medical and legal documentation at both the federal and state levels. (New HOD Policy)

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

Date Received: 9/3/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-26)

Introduced by: Ohio

Subject: Surgical Consent

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, Ohio Rule [4731-25-08](#) section A calls for the surgeon to personally examine a patient
2 for elective surgery and personally obtain informed consent; and
3

4 Whereas, several physicians are relegating the initial determination of need for surgery to their
5 PA or NPs without examining the patient themselves. The first time that the physician personally
6 meets the patient, performs a physical exam, and obtains informed consent is in preoperative
7 area, immediately prior to the patient's scheduled procedure. This means that the initial decision
8 for surgery was initially made by a non-physician and not the surgeon; and
9

10 Whereas, the surgeon potentially disagreeing with the relegated decision for surgery at the last
11 moment may disrupt the ethical integrity of the patient-physician relationship and informed
12 consent process; and
13

14 Whereas, AMA Code of Medical Ethics does not address the delegation of initial determination
15 of need for surgery and surgical informed consent to a non-physician under CEJA [Opinion 2.1.1](#)
16 [Informed Consent](#); and
17

18 Whereas, this mechanism seems to be skirting the ethical guidelines of informed consent; and
19

20 Whereas, AMA ethical guidelines are not clearly defining this practice arrangement; therefore be
21 it
22

23 RESOLVED, that our American Medical Association re-evaluate its CEJA guidelines regarding
24 initial decision for surgery and informed consent - as practice patterns have changed and more
25 team-based care is being utilized - in order to prioritize and strengthen the physician-patient
26 relationship prior to all medical procedures and interventions (Directive to Take Action); and be
27 it further
28

29 RESOLVED, that our AMA facilitate the creation of specialty-specific guidelines, inclusive of the
30 entire house of medicine, defining meaningful supervision and informed consent processes for
31 physician-led care. (Directive to Take Action)

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

Received: 9/1/26

REFERENCES:

AMA Code of Medical Ethics CEJA [Opinion 2.1.1 Informed Consent](#).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, online prediction market platforms, including Kalshi and Polymarket, have begun
2 offering trades on the outcomes of clinical trials and on whether the U.S. Food and Drug
3 Administration will approve new medications, with billions of dollars traded weekly on these
4 lightly regulated platforms¹; and
5

6 Whereas, investigators, research coordinators, pharmacists, and other trial personnel can
7 directly influence the outcomes being traded, creating financial incentives to alter dosing, data
8 collection, or trial conduct for a betting payout, thereby compromising scientific objectivity, trial
9 integrity, and patient safety^{1,2}; and
10

11 Whereas, trading by individuals with inside knowledge of confidential, unpublished trial data
12 constitutes insider betting that platform surveillance safeguards cannot reliably prevent given
13 the large number of personnel involved in the conduct of clinical trials¹; and
14

15 Whereas, markets that reward bets on trial failure allow speculators to profit from the suffering
16 of seriously ill patients and erode public trust in biomedical research and the physicians and
17 scientists who conduct it¹; and
18

19 Whereas, the AMA Code of Medical Ethics obligates physicians engaged in research to
20 safeguard scientific integrity and to avoid financial conflicts of interest that could compromise
21 the objectivity of research or the welfare of participants, yet does not currently address trading
22 on research outcomes³; therefore be it
23

24 RESOLVED, that our American Medical Association strongly oppose the inclusion of biomedical
25 research, including clinical trial outcomes and regulatory approval decisions, as subjects of
26 trading on online betting platforms or prediction markets (New HOD Policy); and be it further
27

28 RESOLVED, that our AMA asks the Council on Ethical and Judicial Affairs to review and update
29 the Code of Medical Ethics to address participation by physicians, medical trainees and other
30 research personnel in trading on the outcomes of biomedical research and clinical trials
31 (Directive to Take Action).

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

Received: 9/16/26

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3. American Medical Association. Code of Medical Ethics, Chapter 7: Opinions on Research & Innovation (including Opinion 7.1.4, Conflicts of Interest in Research).
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RELEVANT AMA POLICY

H-275.939 Internet Gambling

1. Our American Medical Association informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children.
2. Our AMA supports efforts to establish federal and state consumer protections for online gambling, including sports betting, prediction markets, and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors.
3. Our AMA supports epidemiological research to characterize the health impacts of online gambling, including sports betting, prediction markets, and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-26)

Introduced by: Senior Physicians Section
Subject: Ethics of Medical Usury
Referred to: Reference Committee on Ethics and Bylaws

Whereas, the fragmented system of healthcare in the U.S. has led to a crisis of both the uninsured and underinsured, with four out of ten patients unable to afford a medical debt of even \$400, and that medical debt is the leading cause of bankruptcy^{1,2}; and

Whereas, due to recent federal legislative actions the population of those losing both private and public insurance will be significantly higher; and

Whereas, the current administration has proposed administrative rules that would allow insurance companies to offer interest bearing loans to patients unable to afford their medical bills³; and

Whereas, the ethics of insurance companies potentially trapping patients in long term debt has not been previously addressed; therefore be it

RESOLVED, that our American Medical Association recommends to CEJA that it develop statements and policy regarding the ethics of private insurance companies offering interest bearing loans to patients otherwise unable to afford medical debt. (Directive to Take Action)

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

Received: 9/16/26

REFERENCES

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2. Medical Bankruptcy Fairness Act of 2024, One-Pager. [whitehouse.senate.gov](https://www.whitehouse.senate.gov).
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RELEVANT AMA POLICY

D-180.979 Health Plan Payment of Patient Cost-Sharing

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

[CMS Rep. 09, A-19]

H-155.954 Nonprofit Hospital Policies

1. Our American Medical Association advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a “community benefit” that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.
5. Our AMA advocates for the development of transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
6. Our AMA advocates for transparency and consistency regarding governmental oversight of nonprofit hospitals, enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.
7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement.

[CMS Rep. 01, I-24; Modified: CMS Rep. 09, A-26]

H-373.990 Patient Medical Debt

1. Our American Medical Association encourages health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.
2. Our AMA supports innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.
3. Our AMA supports amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection.
4. Our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing.
5. Our AMA supports patient education on medical debt that addresses dimensions such as:
 - a. patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
 - b. the ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
 - c. potential financial aid available from a patient's hospital and/or physician's office; and
 - d. methods to reduce high deductibles and cost-sharing.

[CMS Rep. 05, A-24]

H-373.996 Exclusion of Medical Debt That Has Been Fully Paid or Settled

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

[Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-26)

Introduced by: LGBTQ+ Section

Subject: Opposing the Required Creation of “Detransition Clinics

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, there gender-affirming care for youth is multifaceted, medically necessary, and
2 evidence-based¹⁻³; and
3

4 Whereas, recent federal actions, including executive orders, agency directives, regulatory
5 proposals, or funding conditions, have sought to criminalize or restrict access to gender-
6 affirming care through a variety of mechanisms including funding^{4,5}; and
7

8 Whereas, recent governmental actions and lawsuits seeking to limit access to gender-affirming
9 care have mandated institutions open “Detransition Clinics”^{6,7}; and
10

11 Whereas, there are no clinical guidelines or expert consensus to outline “detransition” care⁸; and
12

13 Whereas, “detransition” care is contained within the spectrum of gender-affirming care, not a
14 separate entity, as it is still care that helps a patient align with their gender identity; and
15

16 Whereas, the percentage of those who “detransition” or those who have regret of obtaining
17 gender affirming care, both with medication and surgery is low and lower than many other
18 standard of care therapies^{9,10}; and
19

20 Whereas, of those who detransition, most report external factors such as pressure from others
21 and societal stigma as primary reasons for their detransition¹¹; and
22

23 Whereas, mandating detransition clinics fuels harmful ideology labeling gender affirming care as
24 abuse, attempting to criminalize physicians and parents^{7,12}; and
25

26 Whereas, these settlements have been costly for hospitals, resulted in the firing of doctors and
27 financial impact covering services, shifting resources away from all other avenues of care^{6,7,13};
28 and
29

30 Whereas, “detransition” is a rare yet real experience for some patients and the receipt of
31 medical care to assist in a patient’s choice to detransition is encompassed within the spectrum
32 of gender-affirming care decisions that should be kept contained within the patient-physician
33 relationship rather than extended to legal or regulatory enforcement methods for patients and
34 providers; therefore be it
35

36 RESOLVED, that our American Medical Association opposes creation of “Detransition Clinics”
37 through mechanisms including but not limited to, legal settlements, executive orders, agency
38 directives or funding conditions. (New HOD Policy)

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

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RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
 - a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
 - b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
 - c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
 - d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers. [Res. 05, A-16Modified: Res. 015, A-21Modified: Res. 223, A-23Appended: Res. 304, A-23Reaffirmed: CSAPH Rep. 08, A-24Reaffirmed: BOT Rep. 23, I-24]

Gender Affirming Healthcare and Research D-460.957

1. Our American Medical Association affirms that gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians, when applicable.
 2. Our AMA advocates and supports new and restored funding, as well as opportunities for GAHC research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity.
 3. Our AMA will collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making GAHC.
- [Res. 509, A-26]

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

1. Our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers.
2. Our AMA supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process. [Res. 014, A-22Reaffirmed: CSAPH Rep. 08, A-24Reaffirmed: BOT Rep. 23, I-24]

Advocating for the Informed Consent for Access to Transgender Health H-185.905

Our American Medical Association unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria. [BOT Rep. 23, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-26)

Introduced by: Resident and Fellow Section

Subject: Recognition of Moral Injury in the Physician Workforce

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, moral injury describes the psychological wounds sustained by physicians when
2 systemic constraints force them to provide care they know to be inadequate, inequitable, or
3 harmful^{1, 2}; and
4

5 Whereas, moral injury is distinct from burnout; burnout comprises emotional exhaustion,
6 depersonalization, and diminished personal accomplishment attributed to demand-resource
7 mismatches, while moral injury reflects systemic and institutional failures that produce guilt,
8 shame, loss of meaning, and erosion of professional identity when physicians cannot deliver
9 care aligned with their ethical and medical obligations²⁻⁴; and
10

11 Whereas, distinguishing moral injury from burnout is valuable because individual-level burnout
12 interventions such as resilience training, mindfulness, and wellness initiatives have been
13 ineffective at meaningfully addressing physician distress, as moral injury requires systemic
14 solutions that address the organizational and policy conditions generating moral conflicts^{5, 6}; and
15

16 Whereas, the 2026 Physicians for a National Health Program (PNHP) survey found that nearly
17 50% of practicing physicians often or always felt unable to provide optimal care due to
18 inadequate time or insurance barriers⁷; and
19

20 Whereas, the PNHP report further identified that systemic contributors to moral injury include
21 prior authorization requirements, coverage denials, productivity quotas, excessive
22 documentation, and the financialization of healthcare, which obstruct timely, evidence-based,
23 patient-centered care⁷; and
24

25 Whereas, moral injury contributes to physician workforce attrition, with 25% of PNHP surveyed
26 physicians currently considering leaving a position due to moral distress and 27% having
27 already left a position for this reason, and a 2021 AMA survey found that one-in-five physicians
28 were planning to retire within two years^{7, 9}; and
29

30 Whereas, moral injury also impacts medical students and residents, with 25% of medical
31 students in the United States considering quitting their studies, and structural sources of moral
32 injury may differ across medical students, residents, fellows, and practicing physicians, such as
33 medical students having ample time to learn about their patients social determinants of health
34 but realizing resources are not available to address these needs, residents studying the most
35 evidence based intervention but finding it inaccessible based on payor status, or attendings
36 spending more time handling authorizations than with their patients; warranting further
37 investigation across all career stages^{7, 10}; and

Whereas, the 2024 AMA Prior Authorization Physician Survey found that nearly all physicians encountered adverse effects from prior authorization, with 29% reporting that prior authorization has led to a serious adverse event¹¹; therefore be it

RESOLVED, that our American Medical Association defines moral injury as the harm that occurs when healthcare professionals are compelled by systemic constraints to act in ways that transgress their moral beliefs and professional obligations, including the inability to deliver evidence-based, equitable, and patient-centered care due to institutional, financial, or administrative barriers (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes moral injury as a distinct and significant threat to the wellbeing of medical students, residents, and physicians (New HOD Policy); and be it further

RESOLVED, that our AMA study the prevalence, drivers, and impact of moral injury across the continuum of medical training and practice, including medical students, residents, and practicing physicians, and report back with recommendations for systemic interventions. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical

Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.\
9. Our AMA will continue to:
 - a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows and regulatory oversight.
 - b. develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
10. Our AMA supports physicians who are caregivers to alleviate physician burnout.

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Peer Support Groups for Second Victims D-405.980

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the "second victim phenomenon"; and (2) will work with other interested organizations to encourage that any future surveys of physician **burnout** should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" on our physician workforce.

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Curricular Structure Reform to Support Physician and Trainee Well-Being H-295.838

1. Our AMA promotes a systems approach to student well-being and support research into the impact (beneficial or deleterious) of various educational structures and processes, including but not limited to, the use of third-party resources and distance learning, upon learner well-being, self-efficacy, and the skills needed to become a practicing physician.
2. Our AMA discourages burnout prevention programs that impose inflexible requirements, additional time burdens on physicians, residents, fellows, and medical students, mandatory assignments, or punitive measures, except where required by law.

3. Our AMA supports evidence-based burnout prevention programs that allow for voluntary participation, options to complete any expectations or activities flexibly, and recognize the importance of personal time for burnout prevention and wellbeing while maintaining the core pedagogy of medical training.
4. Our AMA encourages funding entities and training programs to support the implementation of evidence-based evaluation strategies for the ongoing assessment and improvement of burnout prevention programs.

Factors Causing Burnout H-405.948

Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to **burnout** during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-26)

Introduced by: Underrepresented in Medicine Advocacy Section, Resident and Fellow
Section

Subject: Ensuring the Appropriate Placement of Children After Parental Deportation

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, 5.8 million U.S. households are home to at least one undocumented resident, 5.5
2 million children in these households were born in the U.S., and 1.8 million children live in a
3 household with two undocumented parents¹; and
4

5 Whereas, there is an estimated 145,000 U.S. citizen children with one parent in immigration
6 detention, and more than 22,000 of these children have two parents in custody^{2,3}; and
7

8 Whereas, approximately 36.5% of these children are <6 years old, 36.1% aged 6-12, and 27.4%
9 aged 13-17²; and
10

11 Whereas, parental detention and deportation can disrupt established family caregiving
12 arrangements and impose substantial economic and societal costs associated with providing
13 continued care for affected U.S.-born children¹; and
14

15 Whereas, separation from a primary caregiver during critical developmental periods removes
16 the child's primary stress buffer, inducing toxic stress that impairs emotional co-regulation and
17 physiologic functioning⁴; and
18

19 Whereas, U.S.-born Latino children ages 6-12 whose parents were detained or deported
20 exhibited significantly greater post-traumatic stress symptoms, internalizing problems, suicidal
21 ideation, and poorer overall functioning than peers without such exposure^{5,6}; and
22

23 Whereas, U.S.-citizen adolescents who recently experienced parental deportation had
24 significantly worse health status and more behavioral problems than adolescents in comparable
25 families⁷; and
26

27 Whereas, among 190 children affected by parental arrest, detention, or deportation, over half
28 cried frequently and one-third had concurrent sleep, eating, and crying disturbances persisting
29 beyond nine months, worsening with longer separation⁸; and
30

31 Whereas, judicial precedent, federal child welfare law, and Immigration and Customs
32 Enforcement (ICE) Directive 11064.4 recognize parental rights in determining the placement of
33 their children, but do not mandate safety screening of designated caregivers before placement⁹⁻
34 ¹¹; and
35

36 Whereas, ICE does not always follow Directive 11064.4, particularly in cases where a final order
37 of removal was issued, and the individual is deported rapidly^{12,13}; and
38

39 Whereas, federal oversight has found that ICE does not consistently document detained

1 parents' custody preferences or track whether children were placed with a designated caregiver,
2 leaving no auditable record of placement decisions prior to removal^{14,15}; and
3

4 Whereas, immigration enforcement-related parental separation is associated with increased
5 foster care entry, and the absence of a standardized federal process has left families reliant on
6 informal arrangements outside child welfare systems and states with fragmented caregiver
7 designation mechanisms^{13,16}; and
8

9 Whereas, such informal arrangements culminated in the murder of a child after his mother was
10 deported¹⁷; and
11

12 Whereas, children held in ICE or contracted detention facilities have faced unsanitary conditions
13 and inadequate access to medical care, food, and water, with a congressional investigation
14 citing credible reports of human rights abuses¹⁸; and
15

16 Whereas, ICE data fields implemented in September 2025 on detained parents and their minor
17 children do not capture the physical, developmental, behavioral, or mental-health outcomes of
18 affected children¹⁹; and
19

20 Whereas, the American Academy of Pediatrics, American Academy of Child and Adolescent
21 Psychiatry, and American Psychiatric Association have policies that recommend trauma
22 evaluation and care coordination, and support expeditious reunification of children separated
23 from their parents²⁰⁻²²; and
24

25 Whereas, current AMA policy address the health and wellbeing of children during deportation
26 proceedings, but not after, or the parent's autonomy in deciding where their child is placed; and
27

28 Whereas, the scale and severity of harm to U.S.-citizen children of deported parents stands in
29 contrast to the absence of any federal process for honoring parental placement decisions,
30 screening substitute caregivers, reporting these children's health outcomes, or connecting them
31 to timely health and social services; therefore be it
32

33 RESOLVED, that our American Medical Association support policies that preserve the ability of
34 parents or primary caregivers who are detained or deported to participate in decisions regarding
35 their child's health and wellbeing, including designation of an appropriate caregiver, consistent
36 with the child's safety and applicable law (New HOD Policy); and be it further
37

38 RESOLVED, that our AMA advocate for safe, timely, culturally and linguistically appropriate,
39 and trauma-informed processes to ensure continuity of health care for children experiencing
40 immigration enforcement-related separation from a parent or primary caregiver (New HOD
41 Policy); and be it further
42

43 RESOLVED, that our AMA support privacy-protective mechanisms for secure communication
44 between detained or deported parents and designated caregivers to facilitate continuity of care
45 and health care decision-making. (New HOD Policy)

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

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RELEVANT AMA POLICY

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.
6. Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.
7. Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers.

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

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

Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children H-60.905

1. Our AMA objects to policies separating undocumented, immigrant parents or guardians from children.
2. Our AMA only supports the practice of administering psychotropic drugs to immigrant children when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others.
3. Our AMA (a) supports education for immigration officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (b) encourages policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-26)

Introduced by: New Jersey

Subject: Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring

Referred to: Reference Committee on Ethics and Bylaws

Whereas, American Medical Association ethics affirm human dignity and the right to be free from unreasonable bodily restraint, directing use of the least restrictive means necessary;^{1, 2} and

Whereas, safety measures must not themselves cause preventable harm¹⁴⁻¹⁷, and unnecessary shackles, ankle monitors, or other restrictive or stigmatizing devices can cause physical and psychological harm, humiliation, stigma, and loss of dignity;^{5-13, 18-24} and

Whereas, existing AMA policy opposes universal shackling of incarcerated patients in medical settings, supporting individualized assessment and restraint only when a demonstrated need exists;^{3, 4} and

Whereas, existing AMA policy does not expressly extend these safeguards to the use of restraints or monitoring outside health care settings;^{3, 4} therefore be it

RESOLVED, that our American Medical Association advocate against the routine use of shackles, ankle monitors, or other restrictive or stigmatizing devices unless an individualized assessment by a qualified professional establishes a substantial safety need that cannot be addressed by less restrictive means (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies requiring such measures to be the least restrictive necessary, regularly reassessed, and promptly discontinued when no longer needed, consistent with Code of Medical Ethics Opinion 1.2.7. (New HOD Policy)

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

Received: 9/15/26

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2. American Medical Association. Code of Medical Ethics Opinion 1.2.7: Use of Restraints. Recognizes the fundamental right to be free from unreasonable bodily restraint and calls for the least restrictive restraint reasonable, regular review, and prompt removal when no longer needed.
3. American Medical Association. Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals. Policy H-430.974. Adopted 2025 from Council on Science and Public Health Report 04-A-25.
4. American Medical Association. Shackling of Pregnant Women in Labor. Policy H-420.957. Adopted 2010; reaffirmed 2025.
5. American Public Health Association. A Call to Stop Shackling Incarcerated Patients Seeking Health Care. Policy Statement 20233. Adopted November 13, 2023.
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15. United Nations General Assembly. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). GA Res 70/175, annex, rules 1 and 47-49. December 17, 2015.
16. Council of Europe, Committee of Ministers. Recommendation CM/Rec(2014)4 to member States on electronic monitoring. Adopted February 19, 2014.
17. 42 CFR § 482.13(e), Condition of participation: patient's rights—restraint or seclusion. Electronic Code of Federal Regulations.
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RELEVANT AMA POLICY

Use of Restraints E-1.2.7

All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:

- (a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
- (b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate: (i) why restraint is recommended; (ii) what type of restraint will be used; and (iii) the length of time for which restraint is intended to be used.
- (c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed. *[Issued: 2016]*

Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals H-430.974

1. Our AMA opposes the universal shackling of patients in medical settings who are incarcerated as a means of punishment, control, and oppression and believes shackling should only be used when there is an immediate and serious threat of self-harm, harm to others, or risk of elopement, that cannot be reasonably mitigated by other least restrictive means necessary.
2. Our AMA encourages health care facilities, in collaboration with carceral facility leadership and hospital security, to develop and implement policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care. Such policies should include: (a) individualized assessments that allow patients who are incarcerated to be unshackled when appropriate, particularly when incapacitating medical conditions are present such as weakness due to age or clinical condition, sedation, paralysis, dependence on life support, or while receiving end of life care; (b) clearly delineated procedures for shackle removal and/or replacement of shackles with the least restrictive means necessary; and (c) expeditious procedures for health care professionals to communicate to and collaborate with the decision-making authority of carceral facilities and hospital security to allow timely shackle removal when medically necessary to provide the standard of care.
3. Our AMA urges, through its representation on the National Commission on Correctional Health Care, development and implementation of policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care.

[CSAPH Report 04-A-25; adopted as amended, A-25]

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993

1. Our American Medical Association supports the development of:
 1. Best practices for acute care of patients in the custody of law enforcement or corrections.
 2. Clearly defined and consistently implemented processes between health care professionals and law enforcement that:
 - a. can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and
 - b. ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and
 3. If conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison.
2. Our AMA affirms that:
 1. the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.
 2. it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
3. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.
4. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.

[Res. 407, A-22; Modified: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 4, I-23]

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language adopted by the New Mexico legislature that 'an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used.'

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. *[Res. 203, A-10; reaffirmed 2025]*

CMS Interim Final Rule on the Use of Seclusion and Restraints H-280.952

Our AMA uses the following principles in establishing policy regarding restraints and seclusion:

- (1) the patient has the right to be free of restraints and seclusion unless medically necessary.
- (2) the least restrictive means be considered first.
- (3) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.
- (4) when a physician is not physically present a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard.

[Sub. Res. 101, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]