

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 05 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
- 11 National Guidelines for Guardianship
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- 021* Free Speech and Civil Discourse in the American Medical Association
- 022* Prohibition of Racist Characterization Based on Personal Attributes

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-N-21

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

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations
2 from Discrimination and Harassment,” instructs the American Medical Association (AMA) to:

- 3
- 4 (1) undertake a study to identify all discrimination and harassment references in AMA policies
5 and the code of ethics, noting when the language is consistent and when it is not;
6
- 7 (2) research language and terms used by other national organizations and the federal
8 government in their policies on discrimination and harassment; and
9
- 10 (3) present the preliminary study results to the Minority Affairs Section, the Women’s
11 Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on
12 optimal language to protect vulnerable populations including racial and ethnic minorities,
13 sexual and gender minorities, and women, from discrimination and harassment; and
14
- 15 (4) produce a report within 18 months with study results and recommendations.
16

17 BACKGROUND

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19 Original Resolution 009-A-19 observes that while the “concept of protection against discrimination
20 or harassment is not controversial . . . generally accepted, standard language for protected classes
21 or groups does not exist among national organizations.”
22

23 Federal law establishes a variety of characteristics as defining “protected classes”: race; color;
24 religion or creed; national origin or ancestry; sex, including gender, pregnancy, sexual orientation,
25 and gender identity; age; physical or mental disability; veteran status; genetic information;
26 citizenship; and military status. Relevant laws are as follows:
27

28 Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e) prohibits discrimination based on
29 race, color, sex—including amendments by the Pregnancy Discrimination Act and Civil Rights
30 Act of 1991, national origin, and religion. Title I and Title V of the Americans with Disabilities
31 Act (42 U.S.C. §§ 12101-12113) prohibits discrimination based on disability—including
32 amendments by the Civil Rights Act of 1991 and the Americans with Disabilities Act
33 Amendments Act. The Rehabilitation Act (29 U.S.C. §§ 791, 793, 794, and 794a) prohibits
34 discrimination based on disability in federal employment by employers with federal contracts
35 or subcontracts that exceed \$10,000 and by employers that receive federal funds. The Age
36 Discrimination in Employment Act (29 U.S.C. §§ 621-634) prohibits discrimination based on
37 ages 40 and over. The Genetic Information Nondiscrimination Act (42 U.S.C. § 2000ff)

prohibits discrimination based on genetic information. The Uniformed Services Employment and Reemployment Rights Act (38 U.S.C. § 4311) prohibits discrimination based on past, current, or prospective military service. Section 1981 of the Civil Rights Act of 1866 (42 U.S.C. § 1981) prohibits discrimination based on race, color, and ethnicity in contracts, including most employment arrangements. The Equal Pay Act (29 U.S.C. § 209(d)) prohibits sex-based wage discrimination against men or women performing substantially equal work in the same establishment. The Immigration Reform and Control Act (Pub. L. 99-603, 100 Stat. 3359 (1986)) prohibits citizenship discrimination, national origin discrimination by certain employers, and over-documentation in the employment eligibility verification process [[PracticalLaw](#)].

States may extend protections more broadly – for example, California protects individuals against discrimination on the basis of “marital status”; includes “childbirth, breastfeeding, and/or related medical conditions” within the protected category of “sex”; and explicitly prohibits discrimination on the basis of request for family care leave or for an employee’s own serious medical condition [[CA State Senate](#)].

CURRENT AMA POLICY

A search of AMA’s policy compendium (PolicyFinder) using the terms “discrimination” and “harassment” returned 73 results, covering AMA Bylaws and governance policy, the AMA *Code of Medical Ethics*, and directives and policies of the AMA House of Delegates. After eliminating duplicate entries and excluding policies that did not address discrimination on the basis of personal or practice characteristics the remaining 54 policies were reviewed for the characteristics they delineate (Appendix I).

Of these, 10 adopt at least four of the “protected classes” recognized in law. However, no two policies adopt precisely the same set of characteristics or express them in precisely the same language. Thus Bylaw 1.4 prohibits denying membership in AMA on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, “or for any other reason unrelated to character, competence, ethics, professional status or professional activities.” Opinion 9.5.4, “Civil Rights & Medical Professionals,” in the *Code of Medical Ethics* enumerates a fundamentally similar, but nonetheless not identical set: race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, and disability, but uses the same language to qualify its guidance: “or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.”

H-140.837, “Policy on Conduct at AMA Meetings and Events,” delineates yet a further, albeit related, set of characteristics: race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship “or otherwise.” While H-65.965, “Support for Human Rights and Freedom,” prohibits discrimination on the basis of “sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin or age” or “any other such reprehensible policies.” H-310.919 opposes questioning residency or fellowship applicants about “marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion” as discriminatory, yet H-65.978, “Nondiscrimination Toward Residency Applicants,” calls on the Accreditation Council for Graduate Medical Education to amend institutional requirements to prohibit discrimination based on the more limited set of age, sex, race, creed, national origin, gender identity and sexual orientation.

As Appendix I details, the remaining policies address discrimination in reference to fewer of the characteristics that define protected classes or to other characteristics entirely:

Characteristic	No. of Policies
Sex/gender (including gender identity)	8
National origin (more specifically, IMG status)	6
Genetic information	4
Disability	2
Race/ethnicity	1
Religion	1
Age	1
Other	14

The “other” characteristics set out in various policies included status as an international medical graduate; enrollment in a physician health program, osteopathic or allopathic training; and status as a living organ donor. Table 1 presents the specific choices made across AMA policies on discrimination.

POLICY OF OTHER ORGANIZATIONS

For purposes of comparison, publicly available policies or position statements relating to discrimination were retrieved for 27 organizations: four federal agencies, 13 major specialty societies in the AMA House of Delegates, and 10 academic institutions (Appendix II).

Not surprisingly, public statements of nondiscrimination by the Office for Civil Rights of the Department of Education, the Equal Employment Opportunity Commission (EEOC) of the Department of Labor, the Department of Health and Human Services, and the Office of Fair Housing and Equal Opportunity of the Department of Housing and Urban Development employ the protected classes as defined in federal law.

The federal protected classes form the foundation in policy and position statements reviewed from professional medical organizations. These policies nonetheless differ significantly in how finely they parse the universe of possible personal characteristics or social categories to identify those they deem most pertinent to nondiscrimination policy. Policy of the American Academy of Family Physicians, for example, recognizes not only “socioeconomic status” as a protected feature, but also “body habitus,” while the American Heart Association condemns discrimination on the basis of zip code and primary language, as well as on traditional grounds for protection. The American Academy of Pediatrics (AAP) extends its policy to prohibit discrimination based on the patient’s disability or “the disability of the patient’s parent(s) or guardian(s).” Among the 18 characteristics set out in the statement on nondiscrimination of the American College of Emergency Physicians are socioeconomic status, immigration status, and language preference. Characteristics set out in policy of the American Academy of Hospice and Palliative Medicine include education, political opinion and professional experience.

Using various language, several policies extend protection to “any other characteristic prohibited by applicable federal, state, or local law” (American Urological Association). The National Association of Medical Examiners, in contrast, condemns discrimination based on delineated characteristics and “any other human condition or choice.”

Table 1. AMA policies

Table 1. AMA policies		AMA Policies																															
categories/characteristics cited	8.1.4	9.5.4	H-140.837	H-235.935	H-235.985	D-185.981	H-310.919	H-65.985	H-235.989	8.5	H-184.950	H-310.976	H-525.998	H-525.991	H-65.981	H-60.919	H-235.986	H-235.978	H-235.988	4.1.3	7.3.7	H-305.983	65.989	H-310.923	H-310.923	H-12.916	H-10.914	D-85.991	D-95.984	H-235.984	H-235.949	H-310.985	
age	x	x	x	x	x	x	x	x	x																	x							
ancestry																																	
appearance																																	
body habitus																																	
citizenship			x																														
color	x	x	x			x																											
creed	x	x							x																								
disability	x	x	x	x		x		x																				x					
education																																	
ethnic origin	x	x		x	x			x																									
family status		x																															
gender		x						x		x	x	x			x																		
gender identity	x	x	x	x	x	x		x	x																								
gender expression																x					x												
genetic information																																	
health/health status						x																x	x	x									
immigration status																																	
language preference																																	
marital status			x		x		x																										
medical condition																																	
military/veteran status																																	
national origin	x	x	x			x	x	x	x																								
pregnancy																																	
race	x	x	x	x	x	x	x	x	x															x									
religion	x	x	x	x	x		x	x																		x							
sex	x		x	x	x	x		x	x				x	x																			
sexual orientation	x	x	x	x	x	x	x	x								x																	
social status or condition																																	
socioeconomic status																																	
other basis prohibited by law																																	
other protected group/category/characteristic																																	
other personal category																																	
other social category																																	
other human condition or choice																																	
other legally protected basis																																	
other	x	x	x			x																											
affiliational preferences																																	
country of education or origin																	x																
culture																																	
degree of medical dependency						x																											
dependent status																																	
drug abuse																																	x
employment status																																	
expected length of life						x																											
future plans for marriage or children							x																										
international medical graduate																		x	x														
living donor status																																	x
order of protection status																																	
participation in a PHP																																	x
political opinion																																	
present or predicted disability						x																											
professional experience/profession						x																											
quality of life						x																											
zip code																																	

Like the medical professional society policies reviewed, sample policies of academic institutions that prohibit discrimination—among students, faculty, staff, and, where relevant, patients—are grounded in the protected classes of federal law, but also delineate a wider or more nuanced range of protected characteristics. For example, “order of protection status” and “unfavorable military discharge” (University of Illinois at Chicago); “genetic information or family medical history” (University of Alabama); “associational preferences” (University of Iowa Hospitals & Clinics); “serious medical condition” (University of New Mexico); “family status and responsibilities,” “political affiliation,” “matriculation,” and “unemployed status” (Howard University). Vanderbilt University adopts “sexual orientation” as a protected characteristic but goes on to define it more specifically as “a person’s self-identification as heterosexual, homosexual, bisexual, asexual, pansexual, or uncertain.” In keeping with many others, policies sampled from academic institutions are often open ended” in that they specifically defer to “other protected classes” (or “any other legally protected basis” (University of Alabama).

Table 2 presents the specific choices made across the non-AMA policies reviewed.

THE GOAL OF A COMMON LANGUAGE

Several of the position statements reviewed were triggered by recent events and the impact of the COVID-19 pandemic. For example, the American College of Surgeons’ statement indicates that it responds, at least in part, to “reports of racial and ethnic discrimination during the COVID-19 pandemic,” and is offered as condemnation of such behavior. So too, the statement by the National Academy of Medical Examiners “strongly denounces injustice and racism in all its forms” as a prelude to condemning discrimination on the basis of characteristics the statement then enumerates.

Academic institutions have a clear duty to comply with federal nondiscrimination law, as policy of Vanderbilt University explicitly indicates. The University of Washington grounds its responsibility to provide “equality of opportunity and an environment that fosters respect for all members of the University community,” on the fact that as an institution it is “established and maintained by the people of the state.”

What the statements and policies reviewed demonstrate is that there is no single, agreed on way to speak to discrimination and promote nondiscrimination. In themselves, these materials offer no specific insight into why a particular set of characteristics was adopted or why particular language was used to express those characteristics.

Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S. At the same time, policies among medical professional organizations, including those of the AMA, suggest that beyond that baseline it may be appropriate to focus nondiscrimination policy—and tailor the language used—to the salient issues of the context(s) in which policy is intended to apply. As statements of aspiration for conduct at all times and in all places, policies should be encompassing. As guides for action, they may need to be, and responsibly could be, more narrowly focused.

For example, in light of the distinctive responsibilities physicians and parents/guardians must negotiate in caring for pediatric patients, there is strong rationale for the AAP to oppose discrimination on the basis of the disability status of a patient’s parent(s) or guardian(s). That insight perhaps should inform other health care contexts in which decision making involves multiple parties, but whether the disability status of participants should universally be specifically addressed in nondiscrimination policy is considerably less clear.

[illegible]

1 The policies reviewed further suggest that how a nondiscrimination policy expresses or describes
 2 salient characteristics is also worthy of thoughtful consideration. The majority of documents in the
 3 current, admittedly limited sample, for example, most often refer simply to “disability,” or in some
 4 instances “physical or mental disability,” as a characteristic of concern. The University of Chicago,
 5 however, refers to “status as an individual with a disability,” using “person-first language.” AMA
 6 policy has elsewhere recommended the use of such language (H-440.821).

7
 8 In some circumstances, “context sensitivity” of the sort evidenced in AAP’s nondiscrimination
 9 policy might argue for more granular distinctions with respect to a protected characteristic,
 10 replacing the broadest designation of the relevant characteristic with a set of more nuanced
 11 features. Much as Vanderbilt University’s policy offers secondary interpretation of the
 12 characteristic “sexual orientation” as a range of specific self-identifications. As, indeed, the policies
 13 reviewed suggest is the case in the emerging preference for “gender identity” coupled with “gender
 14 expression” over a monolithic—and increasingly ethically, scientifically, and socially
 15 problematic—characteristic of “gender.”

16
 17 Perhaps the most important consideration for any policy or position statement is the goal it is
 18 intended to serve. Arguably, as the nondiscrimination policy of the University of Iowa eloquently
 19 puts it, the goal is to prevent discrimination on the basis of any classification “that deprives the
 20 person of consideration as an individual.” Seen through an equity lens, that means disrupting the
 21 historical chain of actions that have the effect of discriminating against, marginalizing, or
 22 minoritizing individuals on the basis of actual, perceived, or ascribed characteristics. Words do
 23 matter, but there is not necessarily one and only one vocabulary that can accomplish the goal.

24
 25 These results were circulated to the Governing Councils of the Minority Affairs Section, Women
 26 Physicians Section, LTBTQ Advisory Committee, International Medical Graduate Section, and
 27 Senior Physicians Section. The wide variation in language used across policies of the AMA, other
 28 professional medical organizations, and health care institutions argues that further thoughtful
 29 reflection should be given to deciding what terms will best express AMA’s commitment to equity
 30 and nondiscrimination across our policy compendium, as reflected in the recommendation that
 31 follows.

32 33 RECOMMENDATION

34
 35 In keeping with these considerations, your Board of Trustees recommends that G-600.067, “Terms
 36 and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” be
 37 rescinded, the following be adopted, and the remainder of this report be filed:

- 38
 39 1. That our AMA recommend preferred terminology for protected personal characteristics to be
 40 used in AMA policies and position statements. (Directive to Take Action)

Fiscal note: Less than \$1,500

Appendix I: AMA Policies

AMA Bylaws & governance policy

B-1.4 Discrimination	Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.
Cross-referenced by B-7.1 Resident/Fellow Section B-7.3 Medical Student Section	7.1.4.1 National Resident and Fellow Organizations. National resident and fellow organizations that meet the following criteria may be considered for representation in the Resident and Fellow Section Assembly: c. Membership in the organization must be available to all residents or fellows, without discrimination . 7.3.3.4.1 Criteria for Eligibility. National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting: c. Membership in the organization must be available to all medical students, without discrimination .
G-600.014 Constituent Associations G-600.020 Specialty Organizations	(1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership ;

AMA Code of Medical Ethics

9.5.4 Civil Rights & Medical Professionals	Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities .
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Directives and policies of the House of Delegates

H-140.837 Policy on Conduct at AMA Meetings and Events	Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise , and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such
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	meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
H-295.865 Discrimination Against Patients by Medical Students	Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.
H-295.955 Teacher-Learner Relationship In Medical Education	Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
D-185.981 Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act	Our AMA will work with state medical societies to ensure that no health carrier or its designee may adopt or implement a benefit design that discriminates on the basis of health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.
H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process	Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

H-65.965 Support of Human Rights and Freedom	Our AMA: (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies;
H-65.978 Nondiscrimination in Responding to Terrorism	Our AMA: (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism.
H-295.969 Nondiscrimination Toward Residency Applicants Cross-referenced by H-310.943, Closing of Residency Programs	Our AMA urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."

Appendix II: Professional associations – universities – health centers

<i>Professional Medical Associations</i>	
American College of Emergency Physicians	The American College of Emergency Physicians (ACEP) acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions. These factors are further magnified in the emergency department where cognitive load, rapid and abbreviated interactions, and high stress can leave patients and staff vulnerable to pre-conceived notions and biases. In order to reduce biases and improve health equity, it is crucial to be mindful of their pervasiveness and to employ critical reflection, training, and education geared to address and disarm them. ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices protected by local, state, or federal law. Discrimination and harassment may be based on, but are not limited to, an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military, or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, or sexual orientation.
American Academy of Family Physicians	Patient: The AAFP opposes all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin. Physician: Equal Opportunity--The AAFP strongly supports the principle that hiring, credentialing and privileging decisions for physicians should be based solely on verifiable professional criteria.
American Heart Association American College of Cardiology	(1.4)1. Principles of Professionalism) Social justice. The medical profession must promote justice in the healthcare system, including the fair distribution of healthcare resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, sex, socioeconomic status, ethnicity, religion, or any other social Category. (2.2) 4. The existence and perpetuation of bias and structural racial, ethnic, sex, and other inequities throughout the cardiovascular community must be recognized and acknowledged as a problem, and change must be embraced and incentivized as vital to mission. (2.4) 6. Clinicians should review their own practices at least once per year for possible differential treatment of patients by race and ethnicity, zip code, and primary language.

American Academy of Hospice and Palliative Medicine	Systemic racism undermines public health and poses a barrier to achieving our vision that all patients, families, and caregivers who need it will have access to high-quality hospice and palliative care. We have made the following pledges to achieve Diversity, Equity and Inclusion Build a community and field that is diverse across many dimensions, including but not limited to age, gender, gender identity, ability, education, ethnicity, nationality, political opinion, professional experience, race, religion, sexual orientation, and socioeconomic status.
American Academy of Otolaryngology—Head and Neck Surgery	The AAO-HNS/F is opposed to discrimination against people on the basis of, but not limited to, race, color, national origin, religion, sex (including pregnancy), age, sexual orientation, gender identity and expression, marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law. This applies to all aspects of medical practice and training, practice administration, and academic settings.
American Academy of Pediatrics	THE MISSION OF the American Academy of Pediatrics (AAP) is “to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults.”¹ In support of this mission, therefore, the AAP is opposed to discrimination in the care of any patient on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability of the patient or patient’s parent(s) or guardian(s). In addition, the AAP supports the right of pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other specialist physicians who care for pediatric patients in both educational and practice settings to participate in the delivery of health care without discrimination on the basis of race, ethnicity, ancestry, national origin, religion, gender, marital status, sexual orientation, gender identity or expression, age, veteran status, immigration status, or disability. Physicians with disabilities who maintain the ability to perform the essential functions of their jobs with or without “reasonable accommodation,” as defined by the Americans with Disabilities Act (ADA),² should not be hindered from participating in such activities.
American College of Surgeons	The American College of Surgeons (ACS) is aware of reports of racial and ethnic discrimination during the COVID-19 pandemic. Since this outbreak started, Asian members of both our own surgical community and the public at large continue to experience bias. We strongly condemn these actions. COVID-19 does not discriminate. It affects all people, regardless of gender, race, ethnicity, age, sexual orientation, or geographic location. Discrimination of any kind is antithetical to the mission of any health care professional. We were drawn to this profession to serve all patients.

	The ACS supports all health care personnel who provide essential services in our communities at this time and maintains that they should be able to continue to do so without the specter of hatred and violence resulting from xenophobia, racism, and bigotry. We also encourage you to discuss any discriminatory acts you witness at any time to your institution's leadership and to the ACS.
American Geriatrics Society	The American Geriatrics Society (AGS) opposes discrimination against healthcare professionals or older people based on race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin. We believe that such discriminatory practices can have a negative impact on public health, especially the health of older Americans and vulnerable older people. We oppose any federal order or legislation that unfairly singles out or targets health professionals and other members of the healthcare workforce because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin. Additionally, we oppose discrimination or disparate treatment of any kind in any healthcare setting because of race, color, religion, gender (including gender identity, sexual orientation, and pregnancy), disability, age, or national origin.
American Osteopathic Association Code of Ethics	Section 3. A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients for reasons of discrimination, including, but not limited to, the patient's race, creed, color, sex, national origin, sexual orientation, gender identity, or disability. In emergencies, a physician should make her/his services available. Section 3 does not address a patient's discriminating against a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability; and a patient may express a desire to not be treated by a particular physician or by a physician with certain characteristics. Therefore, the AOA interprets section 3 of its code of ethics to permit but not require an osteopathic physician to treat a patient when the physician reasonably believes the patient is experiencing a life- or limb-threatening event, even though the patient may have previously expressed a desire to not be treated by a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability. (July 2014)
American Society of Colon and Rectal Surgeons	The American Society of Colon and Rectal Surgeons does not discriminate on the basis of race, color, religion, national origin, sex, sexual orientation, age, genetics information, disability, status as a protected veteran, or an any other basis violative of law.

<u>Society for Vascular Surgery</u>	The Society for Vascular Surgery® (SVS) is committed to providing a work environment in which all individuals are treated with respect and dignity. Harassment of any kind, including sexual harassment, is prohibited and will not be tolerated. The Society has zero tolerance of harassment of any kind by anyone, including managers, co-workers, members, vendors, clients, customers, or any other third party. Harassment consists of unwelcome conduct or behavior, whether verbal, physical, or visual, that is based on a person's protected status, including sex, race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability, military status, or any other protected group status.
<u>American Urological Association</u>	The American Urological Association (AUA) and the Urology Care Foundation are committed to promoting a productive work environment that is free from discrimination, harassment or disruptive activity. As such, neither the AUA nor Urology Care Foundation will tolerate verbal or physical conduct by an employee, member, vendor or other that discriminates, harasses, disrupts or unreasonably interferes with another's work performance or creates an intimidating, hostile or offensive working environment. No form of discrimination or harassment will be tolerated based on a person's age, race, color, religion, gender identity and expression, disability, sexual orientation or any other characteristic protected by applicable federal, state and local laws and ordinances.
<u>National Association of Medical Examiners</u>	The National Association of Medical Examiners strongly denounces injustice and racism in all forms. Forensic pathologists are committed to truth, mutual respect for all, listening objectively and understanding between people. Historically, forensic pathologists have stood for truth in Attica, and denounced genocides and many other wrongs flamed by hate and discrimination. We publicly condemn racism, injustice, and discrimination of any kind. We are appalled at the deaths of George Floyd and others before him, murdered and missing indigenous women, attacks on LGBTQT and any attack, injustice or discrimination based on race, gender, ethnicity, sexuality, religious or spiritual beliefs, appearance or any other human condition or choice. We stand united against these terrible injustices. As forensic pathologists and physicians, we are committed to the betterment of humanity, and respect for all people regardless of race, gender, sexuality, ethnicity, religious affiliation, place of birth or economic standing.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-N-21

Subject: National Guidelines for Guardianship
(Resolution 17-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 017-A-19,
2 “National Guidelines for Guardianship” to the Board of Trustees for report. Resolution 017-A-19,
3 introduced by the Medical Student Section, asked that our American Medical Association (AMA)
4 collaborate with relevant stakeholders to advocate for federal creation and adoption of national
5 standards for guardianship programs, appropriate program funding measures, and quality control
6 measures.

7
8 The reference committee heard limited testimony related to this resolution. One speaker lauded the
9 intent of the resolution but expressed concern regarding the complexity of the issue and the need
10 for further study. Testimony was also heard characterizing the resolution as too non-specific in its
11 request. The reference committee recommended that Resolution 017-A-19 be referred.

12
13 The resolution raises vital issues regarding adult guardianship and protection of the elderly. This
14 report presents the current federal and state regulatory framework for laws governing guardianship
15 proceedings, the existing funding and support for programs and education, investigations of
16 suspected elder abuse, and the agencies, associations and commissions that champion these issues.
17 This report analyzes the existing body of AMA policy and *Code of Medical Ethics* opinions and
18 evaluates the adequacy of existing governmental and non-governmental initiatives.

19 20 DISCUSSION

21
22 The resolution focused on the need to assure accountability, safety and transparency in the
23 guardianship process in order to reduce the potential for abuse. Jurisdiction over the guardianship
24 process is within the purview of each state’s court system and relevant state social services and
25 administrative agencies. The obstacles for health care providers in seeking guidance in a patchwork
26 of state laws are evident. However, numerous programs address these obstacles, and several are
27 discussed here.

28 29 *The “Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act”*

30
31 The most ambitious and effective effort to address the inconsistency in state guardianship laws has
32 been undertaken by the National Conference of Commissioners on Uniform State Laws, also
33 known as the Uniform Law Commission (the ULC). The ULC drafted the “Uniform Adult
34 Guardianship and Protective Proceedings Jurisdiction Act” (the [Act](#)). Drafted and recommended by
35 the ULC for enactment in all states, the Act has been adopted in 49 states.

The Act provides states with non-partisan, well-conceived model legislation that brings consistency and stability to this critical area of state law. Jurisdiction of guardianship statutes requires clarity, and the Act addresses the problems of multiple jurisdictions, transfer across state lines, out of state recognition of proceedings and interstate enforcement. In addition, the Act facilitates monitoring of guardian relationships by requiring the court's ability to monitor the guardian as a criterion when adjudicating a guardianship matter. The Act also establishes registration procedures to aid in notification and monitoring of abuse, facilitates cross-border court communication and authorizes a court to order an investigation in another state. Not only does the Act provide a national standard for guardianship programs, it also serves to reduce elder abuse by facilitating improved court monitoring and enforcement guidelines.

The Department of Justice and the American Bar Association Commission on Law and Aging

In 2001, the U.S. Department of Justice (Justice Department) funded the American Bar Association's [Commission on Law and Aging](#) (the ABA Commission) to provide seed funding for a variety of initiatives. One such initiative was coordination of the development of Elder Abuse Fatality Review Teams (EAFRT). EAFRTs examine deaths of individuals that may be caused by or related to elder abuse for the purpose of identifying system gaps and improving victim services. Lessons learned from fatality review teams for child abuse and domestic violence victims have shown a positive impact in improving responses to victims. The Justice Department has further supported technical assistance to coordinate the development of EAFRTs and to publish an instruction manual for replication and implementation. With funding from the U.S. Administration on Aging, the ABA Commission subsequently funded additional EAFRTs through the National Center on Elder Abuse.

In 2017, the Justice Department awarded funding to the ABA Commission and several other organizations for numerous programs and research dedicated to the fight against elder abuse and financial exploitation. The funding has enabled the ABA Commission to build upon the foundational EAFRT model by expanding its initial capacity and evaluating the impact of EAFRTs on victim services. The ABA Commission is currently collaborating with the University of Texas Health Science Center to lead program evaluation activities, establish an expert panel, facilitate information sharing, develop conference presentations and webinars and disseminate products and findings and publish.

By illustration, the ABA Commission's accomplishments in guardianship issues just for the 2019 calendar year included online training for guardians, developing of an annual state guardianship legislative update, collaborating on numerous webinars on guardianship, and working on projects with state stakeholders in Oregon, Florida, and New York to drive changes in guardianship reform. In addition, the ABA Commission on Law and Aging supports a resource and research library providing comprehensive coverage of standards and guidelines for guardianship matters.

The "Elder Justice Act"

Enacted as part of the Patient Protection and Affordable Care Act, the [Elder Justice Act](#) (EJA) establishes national leadership in the Office of the Secretary of Health and Human Services in the form of an Elder Justice Coordinating Council and Advisory Board. This was the first piece of federal legislation passed to authorize a specific source of federal funds to address elder abuse, neglect and exploitation. The EJA authorizes grants to support improvements in Adult Protective Services, Long-Term Care Ombudsman programs, state survey agencies for Medicare and Medicaid, and grants for the establishment of forensic centers. The EJA also provides funding for

1 programs to promote elder justice through the enhancement of long-term care, and evaluation of
2 elder justice programs.

3 4 AMA POLICY

5
6 AMA has an extensive body of policy addressing elder mistreatment, the health care costs of
7 violence and abuse, and preventing, identifying and treating abuse. AMA Code of Ethics Opinion
8 8.10, “Preventing, Identifying and Treating Violence and Abuse,” was issued in 2008 and most
9 recently modified in 2017. The opinion informs of the physician’s ethical obligation to take
10 appropriate action to avert harm caused by violence and abuse. Physicians are charged with
11 numerous responsibilities regarding diagnosing abuse, knowledge of community and health
12 resources, prevention measures, familiarity with reporting obligations, advocating for training in
13 medical education, providing leadership in raising awareness, and supporting research efforts in
14 this area.

15
16 House of Delegates Policy H-515.961, “Elder Mistreatment,” was last modified in 2018 and
17 recognizes elder mistreatment as a pervasive public health issue that requires an organized effort
18 from the medical community to improve recognition and treatment. The policy further advocates
19 for collaboration between the medical team, social services, law enforcement, and the legal system
20 to develop appropriate interventions and evaluation of those interventions. House of Delegates
21 Policy D-515.984, “Health Care Costs of Violence and Abuse Across the Lifespan,” also last
22 modified in 2018, encourages various national agencies to continue to study, conduct research on
23 the cost savings resulting from interventions and to increase funding for research on the impact and
24 costs of elder mistreatment.

25 26 CONCLUSION

27
28 Your Board recognizes the concerns expressed by those who promulgated Resolution 017-A-19.
29 However, we note that AMA has an established and comprehensive body of policy on the matter.
30 Moreover, several federal initiatives address the resolution’s core concerns. The Affordable Care
31 Act, specifically, the Elder Justice Act, created federal leadership and established programs to
32 promote elder justice. The Uniform Law Commission has enacted model guardianship legislation
33 that has been adopted by 49 states. The American Bar Association Commission on Law and Aging
34 has championed the cause for elder justice for forty years. The Department of Justice and other
35 federal agencies provide funding, and numerous agencies, professional associations, academic
36 medical centers and social service organizations continue to develop initiatives, and research
37 outcomes and effectiveness.

38 39 RECOMMENDATIONS

40
41 Your Board of Trustees recommends that the following be adopted in lieu of Resolution 17-A-19,
42 and the remainder of this report be filed:

- 43
44 1. That Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse,” H-515.961,
45 “Elder Mistreatment;” and H-515-984, “Health Care Costs of Violence and Abuse Across the
46 Lifespan,” be reaffirmed. (Reaffirm HOD Policy)
47
48 2. That our AMA support initiatives by the American Bar Association Commission on Law and
49 Aging and other associations and agencies of the federal government to address elder abuse
50 and to ensure consistent protection of elders’ rights in all states. (Directive to Take Action)

Fiscal Note:– Less than \$1,000

AMA POLICY

E-8.10 Preventing, Identifying and Treating Violence and Abuse. All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse. To protect patients' well-being, physicians individually should:

- (a) Become familiar with: (i) how to detect violence or abuse, including cultural variations in response to abuse; (ii) community and health resources available to abused or vulnerable persons; (iii) public health measures that are effective in preventing violence and abuse;
- (iv) legal requirements for reporting violence or abuse.
- (b) Consider abuse as a possible factor in the presentation of medical complaints. (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history. (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions. (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse. (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources. (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should: (i) inform patients about requirements to report; (ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (h) Protect patient privacy when reporting by disclosing only the minimum necessary information. Collectively, physicians should:
- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education. (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed. (k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients. (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
- (m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

H-515.961 Elder Mistreatment

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

D-515.984 Health Care Costs of Violence and Abuse Across the Lifespan.

1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan. 2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse. 3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-N-21

Subject: Study of Forced Organ Harvesting by China

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2019 Interim Meeting, the American Medical Association House of Delegates adopted
2 Policy D-370.981, “Study of Forced Organ Harvesting by China.” The policy directs the AMA to
3 “gather and study all information available and possible on the issue of forced organ harvesting by
4 China and issue a report to our House of Delegates at the 2020 Annual Meeting.”

5
6 The Board of Trustees assigned this report to the Office of International Relations. This report
7 highlights evidence examined on organ transplantation practices in the People’s Republic of China
8 (PRC) and makes recommendations within the context of the AMA’s strategy for involvement in
9 international medical issues.

10 11 BACKGROUND

12
13 The American Medical Association has opined on organ transplantation practices in the PRC for
14 more than a decade, primarily through its membership and active involvement in the World
15 Medical Association (WMA). As early as 2007, a delegation from the WMA visited the Chinese
16 Medical Association (ChMA) to further discuss ethical principles and to seek compliance with
17 WMA ethical principles. The AMA has expressed its consistent support of WMA policy, including
18 [WMA’s Resolution on Organ Donation in China](#). The resolution was first adopted in 2006 and
19 reiterated in 2016 and calls upon the ChMA to cease the practice of using prisoners as organ
20 donors. In 2015, the ChMA reported to the WMA that this practice had been prohibited by the
21 PRC. In 2017, existing WMA policy on organ transplantation was modified to include paragraphs
22 recommending collaboration with governments to ensure that appropriate safeguards are in place to
23 enhance transparency and credibility in the organ transplantation process. At the last meeting of the
24 WMA General Assembly in October 2019, the resolution on organ donation in China was once
25 again submitted for review. The ChMA is now in the process of working with the Medical Ethics
26 Committee of the WMA to revise and clarify this resolution and will formally report its progress to
27 the WMA Council in April 2020.

28 29 AMA POLICY

30
31 AMA has extensive ethics and House policy on issues in organ procurement and transplantation:

- 32
33 • [E-6.1.1, Transplantation of Organs from Living Donors](#)
34 • [E-6.1.2, Organ Donation after Cardiac Death](#)
35 • [E-6.2.1, Guidelines for Organ Transplantation](#)
36 • [E-9.7.3, Capital Punishment](#)
37 • [E-1.2.13, Medical Tourism](#)

- 1 • [H-370.967, Ethical Procurement of Organs for Transplantation](#)
- 2 • [H-370.990, Transplantable Organs as a National Resource](#)

DISCUSSION

There are credible but conflicting and largely anecdotal reports from different sources regarding current transplant practices in the PRC.^{1 2} In 2013, the National Health and Family Planning Commission of the PRC affirmed the government's commitment to aligning transplant practices with guiding principles from the World Health Organization (WHO)³ and the Transplantation Society and International Society of Nephrology's Declaration of Istanbul.⁴ The PRC signed a resolution specifically agreeing to end the practice of accepting organs from condemned prisoners, prohibiting organ trafficking and transplant tourism and strengthening transplant practice and oversight overall.⁵

It appears the development of ethical transplantation practices is a rapidly evolving process in the PRC. While many surgeons and hospitals may be adhering to new standards, there is likely a complex hybrid approach to transplantation includes those who adhere to ethical practices supported officially by the government, and those who may still be operating outside the parameters of international ethical standards.

Scarcity of knowledgeable, independent sources of information limit the transplant community's ability to assess transplant practices in the PRC. Neither the AMA nor the WMA can independently verify sources of transplanted organs or transplantation data, and persistent yet conflicting reports of ethical infractions make it nearly impossible to determine whether any claim of organ sources is indeed what it purports to be.

There is credible evidence to suggest that the PRC's efforts to reform its transplantation practices have not succeeded to the extent the government claims, and that abuses still occur:

- There is no built-in transparency for organ transplantation statistics in China. A detailed statistical analysis published by Israeli researchers in 2019⁶ showed evidence of data manipulation in the organ transplant data sets that were publicly available. Based on available data, they concluded there is no way to definitively extrapolate either the source of organs used, or the total number of transplants performed per year. The study also found evidence that the authors believed indicates donors are being misclassified as "voluntary" when they are not.
- The PRC has relied heavily on organs from executed prisoners and not voluntary organ donors for source organs, a practice which was internationally condemned. The PRC claims to have stopped this practice. Government statistical information indicated a huge increase in voluntary donors, from 23% of organs procured in 2013 to 80% in 2014. The PRC states that voluntary organs then became the sole official organ source in 2015. However, it is not plausible that the country increased its volunteer donor rate from 23% of all organs procured to 100% in just two years. Gains of this magnitude would likely take many years.⁷
- Evidence has been presented⁸ indicating that waiting times for organs are much shorter in the PRC than in the rest of the world, and often as little as two weeks. If accurate, this evidence supports that prisoners are still being used as organ donors, as there does not seem to be a satisfactory alternate explanation.

- 1 • China's history of human rights violations against its religious minorities is well-documented
2 by multiple independent sources.^{9 10 11} These violations make accusations of organ harvesting
3 from among these minorities more credible.
4

5 While progress has likely been made in developing more humane and ethically acceptable
6 transplantation practices in the PRC, the continued lack of transparency and availability of
7 transplantation data hurts its standing in the international community and leads other countries to
8 question claims that harvesting organs from prisoners has conclusively ceased.
9

10 CONCLUSIONS

11
12 The AMA has consistently supported ethical organ transplantation policy at the WMA, and
13 specifically, in its interactions with the Chinese Medical Association. The AMA has strong policies
14 to support our position.
15

16 Neither the WMA nor the AMA can independently verify either the sources of transplanted organs
17 or transplantation data in the PRC.
18

19 Due in part to lack of transparent and readily available organ transplant data, doubts remain as to
20 the success of the PRC's organ transplantation reforms, and there is credible evidence to suggest
21 that abuses may still be taking place.
22

23 RECOMMENDATIONS

24
25 The Board of Trustees recommends that the following be adopted and that the remainder of the
26 report be filed:
27

- 28 1. That our American Medical Association continue to engage the Chinese Medical Association
29 and the transplant community in the People's Republic of China (PRC) through promotion and
30 support of relevant activities and policies of the World Medical Association that relate to organ
31 transplantation. (Directive to Take Action)
32
- 33 2. That our AMA, through its membership in the World Medical Association, continue to call for
34 the PRC's compliance with internationally recognized organ transplantation standards, such as
35 those of the World Health Organization, and for the PRC to make available externally
36 verifiable data on organ transplantation. (Directive to Take Action)
37
- 38 3. That our AMA condemn the retrieval of organs for transplantation without the informed
39 consent of the donor. (New HOD Policy)
40
- 41 4. That Policy D-370.981, "Study of Forced Organ Harvesting by China," be rescinded, having
42 been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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Additional references are available from the AMA Office of International Relations.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-N-21

Subject: Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
(Resolution 1-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2019 Annual Meeting, the House of Delegates (HOD) referred Resolution 1-A-19,
2 “Opposing Attorney Presence at and/or Recording of Independent Medical Examinations” to the
3 Board of Trustees for report. Resolution 1-A-19, introduced by the Illinois Delegation, asked that
4 our American Medical Association (AMA) amend by addition Policy H-365.981, “Workers’
5 Compensation,” to include language that opposes the ability of courts to compel recording and
6 videotaping of, or allow a court reporter or an attorney to be present during the independent
7 medical examination, as a condition precedent to allowing the physician’s medical opinion in court.
8

9 The reference committee heard testimony in opposition to this resolution. Speakers opposing the
10 resolution noted the variability of state laws addressing the recording or videotaping of, or attorney
11 presence at independent medical examinations (IME) for the purpose of resolution of workers’
12 compensation claims. Furthermore, the state specific nature of workers compensation statutes
13 precludes prescribing a national workers’ compensation guideline. Testimony supportive of
14 adopting the resolution noted that the resolution is consistent with the ethical guidelines of our
15 AMA and of other organizations, and the recording or presence of a third party is intrusive to a
16 private medical exam. Given the diverse testimony regarding the resolution, the HOD referred
17 Resolution 1-A-19.
18

19 This report considers the discordancy of existing state laws regarding the physician’s role in IME
20 and presents current AMA policy and *Code of Medical Ethics* opinions. This report analyzes the
21 existing body of AMA policy on the IME in workers’ compensation matters and the physician
22 patient relationship and evaluates the consistency of the proposed resolution with existing policy
23 and concludes with a recommendation for HOD action.
24

25 BACKGROUND

26
27 An IME is a physical examination conducted at the request of a third party, such as an employer or
28 an insurance company. IMEs arise in the context of workers’ compensation injury claims, although
29 an IME may also be utilized in any personal injury claim or in employer mandated pre-employment
30 or annual physical examinations. Our AMA Policy on workers’ compensation (Policy H -365.981)
31 was initially adopted in 1993 and was most recently modified in 2017 to reflect certain goals that
32 had been met. In addition, a number of states allow for attorney presence during examinations
33 pursuant to a showing of good cause, and/or with the consent of the patient.

1 DISCUSSION
2

3 AMA Code of Ethics Opinion 1.1.1, Patient-Physician Relationship, describes the practice of
4 medicine as a moral activity where the relationship between the physician and patient is based on
5 trust. The opinion further addresses circumstances wherein a *limited* patient-physician relationship
6 is created. One example of a limited patient-physician relationship is in the context of an IME. In
7 keeping with ethics guidance, the IME creates a limited patient-physician relationship imposing a
8 duty of care on the physician conducting the IME examination. While this relationship is subject to
9 variable interpretations across the states, our AMA tasks the physician with responsibilities to both
10 the employer or insurer and the patient.
11

12 AMA Code of Medical Ethics E-1.2.6, Work Related & Independent Medical Examinations, states
13 that physicians who provide medical examinations at the request of employers or insurance
14 companies face a conflict of duties. The physician has responsibilities to *both* the patient and the
15 employer or third party. The core obligations of industry-employed physicians to their patients
16 include disclosure of the nature of the relationship between the physician and the patient and the
17 physician's departure from the traditional fiduciary role. The physician's ethical responsibility
18 further obligates the physician to inform the patient about incidental findings discovered during the
19 exam, and when appropriate, suggest follow-up care. If requested, the physician also provides
20 reasonable assistance in securing follow-up care.
21

22 The integrity of the physician-patient relationship is paramount with long-standing and unequivocal
23 policy support by our AMA. Recording equipment, or the presence of an attorney at an IME,
24 interferes with and lends a degree of artificiality to the examination. The need for a confidential
25 and open exchange between the patient and the examining physician is evident. Allowing a third
26 party who has an interest in the outcome of the examination, or recording the examination, could
27 inhibit and intimidate the patient from candid communication during the exam. The intrusion of
28 counsel in the examining room thrusts the adversarial process into the examination room.
29

30 The states have an interest in maintaining the integrity of Workers Compensation claims processes.
31 Numerous states have implemented recording requirements for IME and/or allow an attorney's
32 presence during the exam. While one can recognize the state's interest in attempting to interject a
33 method to document proof of the veracity of the IME, AMA policy is unequivocal on patient
34 privacy and the sanctity of the patient-physician relationship. Furthermore, the claims process is
35 not disadvantaged by the lack of a recording or attorney at the IME. The attorneys and the
36 employer or insurer each receive a copy of the examining physician's written report and can
37 request an additional IME. Most importantly, the attorneys have the opportunity to cross examine
38 the physician in a deposition or at trial. Cross examination of an expert is the industry standard and
39 best practice for obtaining evidence.
40

41 Your Board recognizes the concerns expressed by those who testified in opposition to adoption of
42 the resolution. There are numerous state law approaches to the issue raised by Resolution 1-A-19.
43 The state-specific nature of the laws precludes the prescribing of workers compensation guidelines.
44 Your Board further acknowledges a state's legitimate reasons for recording or having an attorney
45 present during an IME. However, your Board does not believe these considerations outweigh the
46 sanctity of the patient-physician relationship, even in the more limited context of an IME,
47 particularly given the availability of other documentation methods such as written reports and cross
48 examination.

1 CONCLUSION

2
3 As noted in the preceding paragraph, testimony at the reference committee indicated that state laws
4 may differ widely in how they deal with the issues that Resolution 1-A-19 raises, and testimony did
5 not indicate that physicians in all states opposed the manner in which their state's law addressed
6 those issues. Consequently, your Board does not recommend that our AMA adopt a blanket policy
7 requiring your AMA to always oppose instances where a state law or proposed legislation permits
8 the recording of an independent medical examination. Adopting such a blanket policy would
9 obligate our AMA to oppose state laws and legislative proposals in cases where physicians in the
10 state may not wish our AMA to oppose the law or proposal. Your Board recommends that your
11 AMA oppose attorney presence and the recording of IMEs when asked to do so by a state medical
12 association or national medical specialty society. This approach avoids committing our AMA to
13 opposition where none has been requested by the state medical association, yet empowers your
14 AMA to assist those state medical associations who wish to challenge laws or legislative proposals
15 that the association believes unjustifiably intrude into the limited patient-physician relationship
16 created in the context of an IME.

17
18 RECOMMENDATION

19
20 Your Board of Trustees recommends that the following recommendation be adopted in lieu of
21 Resolution 1-A-19 and that the remainder of the report be filed.

22
23 That, upon request of state medical associations and national medical specialty societies, our
24 AMA will provide assistance and consultation in opposing the ability of courts to compel
25 recording and videotaping of, or allow a court reporter or an attorney to be present during the
26 independent medical examination, as a condition precedent to allowing the physician's medical
27 opinion in court. (Directive to Take Action)

Fiscal Note: Less than \$1,000

AMA POLICY

H-365.981, "Workers' Compensation"

Our AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development. (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care. (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment. (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate. (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims. (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners. (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation. (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage. (9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate. (10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

E-1.1.1. Patient-Physician Relationships. The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

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

E-1.2.6: Work Related & Independent Medical Examinations. Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals' health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party. Such industry-employed physicians or independent medical examiners establish limited patient-physician relationships. Their relationships with patients are confined to the isolated examinations; they do not monitor patients' health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role. In keeping with their core obligations as

medical professionals, physicians who practice as industry- employed physicians or independent medical examiners should:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.
- (c) Protect patients' personal health information in keeping with professional standards of confidentiality.
- (d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

E-3.2.3 Industry Employed Physicians and Independent Medical Examiners. Physicians may obtain personal information about patients outside an ongoing patient-physician relationship. For example, physicians may assess an individual's health or disability on behalf of an employer, insurer, or other third party. Or they may obtain information in providing care specifically for a work-related illness or injury. In all these situations, physicians have a responsibility to protect the confidentiality of patient information. When conducting third-party assessments or treating work-related medical conditions, physicians may disclose information to a third party:

- (a) With written or documented consent of the individual (or authorized surrogate); or
 - (b) As required by law, including workmen's compensation law where applicable.
- When disclosing information to third parties, physicians should:
- (c) Restrict disclosure to the minimum necessary information for the intended purpose.
 - (d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.

E- 3.2.1 Confidentiality. Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether and to whom their personal health information is disclosed. However, specific consent is not required in all situations. When disclosing patients' personal health information, physicians should:

- (a) Restrict disclosure to the minimum necessary information; and
 - (b) Notify the patient of the disclosure, when feasible.
- Physicians may disclose personal health information without the specific consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).
- (c) To other health care personnel for purposes of providing care or for health care operations; or
 - (d) To appropriate authorities when disclosure is required by law.
 - (e) To other third parties situated to mitigate the threat when in the physician's judgment there is a reasonable probability that: (i) the patient will seriously harm him/herself; or (ii) the patient will inflict serious physical harm on an identifiable individual or individuals.
- For any other disclosures, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information.

REPORT 16 OF THE BOARD OF TRUSTEES (N-21)
Research Handling of De-Identified Patient Information
(Reference Committee on Amendments to Constitutions and Bylaws)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting, BOT Report 26 was referred back for further study to address questions raised by delegates on whether the recommendations in the original report could impact registries established by medical specialties. In addition, since the 2019 Annual Meeting our AMA has identified new and emerging concerns about de-identified data being re-identified by entities for a variety of purposes.

Protected health information (PHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number) that can be associated with patient health information. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Security of PHI safeguards patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment. However, the use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-N-21

Subject: Research Handling of De-Identified Patient Information

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 INTRODUCTION

2
3 At the 2018 Annual Meeting, Policy D-315.975, “Research Handling of De-Identified Patient
4 Information,” was adopted by the House of Delegates (HOD). This policy directs the American
5 Medical Association (AMA) to study the handling of de-identified patient data and report the
6 findings and recommendations to the HOD at the 2019 Annual Meeting. During the 2019 Annual
7 Meeting of the HOD, Board of Trustees (Board) Report 26 and the recommendations included
8 therein were discussed on the House floor. Specifically, mixed testimony was offered on
9 recommendation two in the original report which recommended that our AMA support state-based
10 efforts to protect patient privacy including a patient’s right to know whether information is being
11 disclosed or sold and to whom, as well as the right to opt out of the sale of their data. Significant
12 testimony was received concerning the impact of that recommendation on registries, its application
13 across inconsistent state laws, as well as on underserved populations. As a result, the HOD referred
14 the report for further study. In addition, since the 2019 Annual Meeting our AMA has grown
15 increasingly concerned that despite data aggregation and the removal of individually identifying
16 characteristics protected health information, de-identified data can and is being re-identified by
17 entities for a variety of purposes.

19 BACKGROUND

20
21 Health-related information collected during the course of clinical care has always been of great
22 interest for a number of secondary use cases, including scientific research in the academic and
23 commercial settings, public health studies, marketing for pharmaceutical and medical device
24 companies, and a wide variety of other uses. More recently, a new and substantial interest has been
25 raised from technology companies who seek to use patient data to build new clinical tools using
26 machine learning and “big data.” Clinical data is the topic of significant ethical guidance and
27 regulation at both the state and federal levels, focused primarily on the appropriate use and
28 handling of identifiable patient information. Little guidance exists, however, on the use of de-
29 identified patient data.

30
31 A variety of entities, including provider organizations, clinical laboratories, and commercial
32 entities such as personal genomics companies, may collect patient data intended for clinical use or
33 to deliver genetics information, and then resell de-identified data to other entities for other
34 purposes. Concerns arise in that when the data is de-identified, it is no longer considered PHI and
35 therefore patient authorization or consent for use is not required and therefore not solicited—
36 meaning that patients are not always aware how their data is being used.¹

In addition, there is both a real and perceived lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior. In addition, the sale of de-identified data by clinicians and provider organizations may create a real or perceived conflict of interest, which could lead to a loss of patient confidence.

What is Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides extensive protections for patient data that is considered protected health information (PHI).² PHI is information, including demographic information, which relates to an individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.³ It should be noted that HIPAA was developed in the era prior to the expansion of machine learning. PHI includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.⁴ These safeguards help protect patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment.^{5,6} Section 164.514(a) of the HIPAA Privacy Rule establishes standards for de-identifying PHI so individuals can no longer be identified by any portion of the data. The use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose otherwise allowed by law.⁷

In addition to regulation at the federal level, state lawmakers have exhibited a general trend toward establishing stricter guards on the use of patient data and the requirement for patient consent, some of which reflect standards set forth in the European Union's recent General Data Protection Regulation (GDPR).⁸ States are increasingly considering and passing laws to protect consumer privacy as it relates to the use of their personal information. For example, California in June 2018 passed the California Consumer Privacy Act of 2018 (effective January 1, 2020), which protects consumers' rights to: (1) know what personal information a for-profit business has collected about them, where it was sourced from, what it is being used for, whether it is being disclosed or sold, and to whom it is being disclosed or sold; (2) "opt out" of allowing a business to sell their personal information to third parties; (3) have a business delete their personal information, with some exceptions; and (4) receive equal service and pricing from a business, even if they exercise their privacy rights under the Act.⁹ California's law does not apply to information covered by HIPAA, de-identified personal data, or aggregate consumer data, however, as long as the de-identification measures meet the Act's strict standards.¹⁰

What is de-identified patient data?

45 CFR §164.514(a) of HIPAA states that "[h]ealth information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information." Removing identifiers from PHI mitigates privacy risks to individuals and thereby supports the secondary use of data for

comparative effectiveness studies, policy assessment, life sciences research, and other endeavors.¹¹ HIPAA requires that covered entities use one of two methods for de-identification: (1) a formal determination by a qualified expert (expert determination); or (2) the removal of specified individual identifiers and an absence of actual knowledge by the covered entity that residual information could be used to identify the individual (safe harbor).

The identifiers that must be removed from PHI in the safe harbor method include:¹²

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
 - The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and
 - The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Fax numbers
- Device identifiers and serial numbers
- Email addresses
- Web URLs
- Social security numbers
- Internet Protocol addresses
- Medical record numbers
- Biometric identifiers, including finger and voice prints
- Health plan beneficiary numbers
- Full-face photographs and any comparable images
- Account numbers
- Any other unique identifying number, characteristic, or code, except as permitted
- Certificate/license numbers

How is de-identified data used?

De-identified data is used for research to derive information and knowledge about treatment and outcomes, as well as other patient care-related purposes. De-identified data is sourced, collected, and used by a variety of organizations, including health care provider organizations such as hospitals or academic medical centers, and commercial enterprises such as personal genomics and biotechnology companies as well as others that may not be directly related to patient care. Pharmaceutical manufacturers and retail pharmacies may also use de-identified health data to target their advertising. Health care providers use this data typically in research or the direct care of patient populations. Many stakeholders assert that de-identified data can help reduce costs of care, improve treatment options, and support public health initiatives.

Machine learning is a family of methods used by some health care and data solution organizations to help predict certain outcomes and better prepare for and treat patients identified to be at risk. Machine learning models establish predictive rules using vast amounts of computing power. The

1 more data a machine learning model has, the more complex the rules and the more accurate the
2 predictions.¹³ However, machine learning models are vulnerable to biases induced by data that does
3 not adequately represent the patient population, such as data collected from only one institution or
4 one geographic region. In order to develop clinical decision support tools that can be effectively
5 used to treat the diverse patient populations in the United States, large amounts of data are
6 required, and often data from many different providers across the country are required to avoid
7 bias. The data are often sourced from de-identified patient records. Allscripts, for example, used 50
8 million de-identified patient records, and the application of an advanced machine learning
9 algorithm, to “train” its systems and further improve its clinical decision support tools.¹⁴
10 Organizations like Orion Health and Precision Driven Health are using datasets like these to
11 generate machine learning aimed at improving health care decisions, and driving operational and
12 cost efficiencies.^{15,16} By combining multiple datasets, such as behavioral data, device use data,
13 patient claim data and socioeconomic and geographic data, these organizations are developing
14 advanced predictive analytics to further improve precision health care.¹⁷ The data used for the
15 purposes of data mining and honing machine learning algorithms are either sourced and used at the
16 organizational level, or de-identified when used for external research, such as the analysis done by
17 Allscripts. Data may be sourced via publicly available de-identified datasets, databases established
18 through collaborative research agreements, or via the purchase of bulk de-identified data, on an
19 exclusive or non-exclusive basis. Since this technology is relatively new in the health care space its
20 implications for patient data are not well-studied. As augmented intelligence and advanced
21 machine learning proliferate in the health care space, the value and number of potential uses of
22 patient health data will inevitably increase. Stakeholders should be prepared for increasing
23 concerns about related patient privacy and data security.

24
25 Commercial entities, such as personal genomics companies, are typically not subject to HIPAA’s
26 rules around privacy and de-identification. They may collect data from consumers and then
27 subsequently sell the de-identified data to another entity for another purpose. For example,
28 23andMe, a genomics and biotech service, sells de-identified user data to pharmaceutical
29 companies that use it to conduct research on various diseases. However, patients are not always
30 aware how their data is being used in these types of scenarios.¹⁸ For example, research using de-
31 identified data may result in scientific knowledge that has commercial value. Proper consent for
32 use and/or disclosure of commercial interest in this research is ideal but inconsistent, sometimes
33 resulting in legal action against physicians or researchers.¹⁹

34
35 In addition, there is a lack of transparency and regulation in how patients’ data is being sold,
36 distributed, or used outside of their direct health care, both by entities subject to HIPAA and
37 commercial actors. Risk of re-identification, which some studies have demonstrated to be possible
38 through matching data to other publicly available data sources, is another issue related to the use of
39 de-identified data. There are also concerns about access to such information that is sought for
40 marketing purposes on behalf of commercial entities that have financial interests in physicians’
41 treatment and/or prescribing behavior.

42 43 AMA POLICY

44
45 The AMA has multiple policies expressing its recognition of the importance of data privacy and
46 protection of PHI, as well as policies expressing commitment to ensuring safe and appropriate use
47 of de-identified data.

48
49 AMA Policy H-315.978, “Privacy and Confidentiality,” states that where possible, informed
50 consent should be obtained before personally identifiable health information is used for any
51 purpose. However, in those situations where specific informed consent is not practical or possible,

1 either (1) the information should have identifying information stripped from it or (2) an objective,
2 publicly accountable entity must determine that patient consent is not required after weighing the
3 risks and benefits of the proposed use. Re-identification of personal health information should only
4 occur with patient consent or with the approval of an objective, publicly accountable entity.

5
6 AMA Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical
7 Record Information," expresses the AMA's commitment to advocating that physicians, as trusted
8 stewards of PHI, should be the owners of all claims data, transactional data and de-identified
9 aggregate data created, established and maintained by a physician practice, regardless of how and
10 where such data is stored but specifically including any such data derived from a physician's
11 medical records, electronic health records, or practice management system.

12
13 AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that whenever possible,
14 medical records should be de-identified for purposes of use for utilization review, panel
15 credentialing, quality assurance, and peer review. This policy also states our AMA will guard
16 against the imposition of unduly restrictive barriers to patient records that would impede or prevent
17 access to data needed for medical or public health research or quality improvement and
18 accreditation activities, and that whenever possible, de-identified data should be used for these
19 purposes. Policy H-315.983, posits that in the event of a sale or discontinuation of a medical
20 practice, only de-identified and/or aggregate data should be used for "business decisions,"
21 including sales, mergers, and similar business transactions when ownership or control of medical
22 records changes hands. This policy includes extensive language emphasizing the AMA's
23 commitment to protecting PHI, and that it will continue its advocacy for privacy and confidentiality
24 regulations, including: (a) The establishment of rules allocating liability for disclosure of
25 identifiable patient medical information between physicians and the health plans of which they are
26 a part, and securing appropriate physician control over the disposition of information from their
27 patients' medical records; (b) The establishment of rules to prevent disclosure of identifiable
28 patient medical information for commercial and marketing purposes; and (c) The establishment of
29 penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

30
31 In AMA Policy H-315.975, "Police, Payer, and Government Access to Patient Health
32 Information," the AMA commits to advocating for narrow and clearly defined bounds for the
33 appropriate use of patient information by law enforcement, payers and government entities, for
34 operations that cannot be reasonably undertaken with de-identified data. AMA Policy H-315.987,
35 "Limiting Access to Medical Records," further defines who should and should not have access to
36 this information.

37
38 The AMA's *Code of Medical Ethics* includes an opinion on "Access to Medical Records by Data
39 Collection Companies." Opinion E-3.2.4 asserts that disclosing information to third parties for
40 commercial purposes without consent undermines trust, violates principles of informed consent and
41 confidentiality, and may harm the integrity of the patient-physician relationship. The opinion
42 further expresses that physicians who wish to permit third-party access to specific patient
43 information for commercial purposes should: (a) only provide data that has been de-identified, and
44 (b) fully inform each patient whose record would be involved about the purpose(s) for which
45 access would be granted. This opinion, with respect to requests for permission to allow access to or
46 disclose a full medical record, prohibits disclosing identifiable information for commercial
47 purposes without obtaining consent from the patient to do so.

48
49 The authors of Resolution 3-A-18, which established Policy D-315.975 and is the subject of this
50 report, expressed particular concern that this *Code of Medical Ethics* Opinion may contradict itself
51 in its emphasis on informing the patient of how their de-identified data will be used and the

subsequent emphasis on the importance of obtaining consent. The key difference between the two elements of the opinion lies in the description of the patient information being requested (specific, de-identified patient information vs. full medical record), thus our AMA does not agree that these statements are contradictory.

The resolutions authors also expressed that this Opinion may be in disharmony with the rules set forth in the HIPAA Privacy Rule, specifically stating that authorization, rather than consent, is sometimes mandated for the release of PHI when being requested for purposes not related to treatment, payment, or health care operations (TPO). Ethical Opinion E-3.2.4 was originally issued in 1994 and updated in 1998, prior to the enactment of the HIPAA Privacy Rule, yet provides an even higher standard than the Rule with respect to requirements for consent to disclose patient data, including data that has been de-identified. With respect to authorization requirements, Opinion E-3.2.4 does not include a statement about when authorization, rather than consent, is appropriate and/or required. Guidance provided in the Code of Medical Ethics is provided by standards of conduct that define the essentials of honorable behavior for the physician. They cover broad ethical principles and are not intended to align with law or specific regulations that may be legally enforceable. During a comprehensive eight-year modernization process that ended in 2017, the *AMA Code of Medical Ethics* was reviewed for relevance/timeliness of guidance, clarity, and consistency of guidance. Opinion E-3.2.4 was reorganized in this process, taking the HIPAA provisions into consideration during the process. Care was taken to ensure the Council on Ethical and Judicial Affairs was conservative in suggesting substantive change, doing so only where needed to ensure that guidance remains relevant in the face of changes in biomedical science and conditions of medical practice. No contradictions or points of discord with HIPAA were identified in that review. It is also worth noting that “authorization” and “consent” are frequently (and often incorrectly) conflated in the context of HIPAA.

DISCUSSION

Oversight of patient information

The use of de-identified patient data is not heavily regulated at the federal level. The HIPAA Privacy Rule does not restrict the use or disclosure of de-identified health information, since it is not considered PHI.^{20,21} HIPAA permits secondary uses of de-identified data for purposes such as public health initiatives, research, law enforcement, and other public interest endeavors.^{22, 23} In addition, commercial entities that sell or use de-identified data, such as biotech, “big data” companies such as Google and Amazon, and pharmaceutical companies, are not considered covered entities under HIPAA. Through their interactions with pharmacy benefit managers, pharmacies, payers, physicians and patients, however, they may be indirectly impacted by privacy rules and thus obliged to structure their transactions, projects, and internal data programs such that their partners that are covered entities or business associates thereof meet data privacy requirements under HIPAA and any other applicable standards.

Studies that use de-identified data are exempt from regulations that govern human subject research.^{24,25} Entities that collect and use consumer data, such as pharmaceutical companies or academic institutions conducting research, should employ privacy protections in their practices, such as data security, reasonable collection limits, sound retention and disposal practices, and data accuracy to protect privacy, as guided in recommendations from the Federal Trade Commission (FTC).²⁶ For example, Harvard University, like many academic institutions receiving federal grants, implements strict policy to govern the collection, storage and use of research data, including PHI.²⁷ In addition to the enforcement of strict policy, all human subject research is subject to approval by the institution’s Institutional Review Board (IRB). It is the responsibility of IRBs to

1 specify the security level for research projects they review and approve, obtain confirmation that
 2 the relevant security controls are being implemented and decide if the human subject must give
 3 consent or in the case of de-identified information, approve the research under an exempt status
 4 from obtaining the consent.

5
 6 Human subject research conducted or supported by certain federal departments or agencies is
 7 governed by the Federal Policy for the Protection of Human Subjects (“Common Rule”). Revisions
 8 to the Common Rule in 2017 were adopted in response to shifts in science, technology, public
 9 engagement, and public expectations that have raised concerns about the limitations of the existing
 10 ethical framework in research.²⁸ The rapid pace of change in the availability, utility, and value of
 11 patient data, including PHI and de-identified data, will continue to necessitate regular
 12 reconsideration of the ethical oversight of patient data and how it is protected by researchers and
 13 other entities.

14 15 *De-identified data and clinical data registries*

16
 17 Clinical data registries sponsored by entities such as national medical societies, or state or local
 18 health departments also collect and analyze data (including PHI) on treatment outcomes submitted
 19 by physicians, hospitals, and other types of health care providers related to a wide variety of
 20 medical procedures, diagnostic tests, and/or clinical conditions. Such registries use the data they
 21 collect to produce benchmarks or metrics that their participating health care providers can use to
 22 improve the quality of care they provide their patients. Registries also conduct (or work with others
 23 to conduct) research on the data they collect to enhance general knowledge about the safety and
 24 effectiveness of various medical procedures, diagnostic tests, treatments, and health care products.
 25 Other registries, such as public health databases, collect data on various population health events
 26 that may or may not involve medical treatment.

27
 28 In 2018, the AMA reaffirmed Policy H-450.933, “Clinical Data Registries.” This policy states, in
 29 part, that “[o]ur AMA encourages multi-stakeholder efforts to develop and fund clinical data
 30 registries for the purpose of facilitating quality improvements and research that result in better
 31 health care, improved population health, and lower costs;” ... “[o]ur AMA supports flexibility in
 32 the development and implementation of clinical data registries;” and “[r]egistries and electronic
 33 health records should be interoperable, and should be capable of sharing and integrating
 34 information across registries and with other data sources in a HIPAA-compliant and confidential
 35 manner.” As evident by the reaffirmation of the Clinical Data Registries policy in 2018, our AMA
 36 does not desire to hinder the efforts of these registries to facilitate quality improvements and
 37 research that result in better health care, improved population health, and lower costs.

38 39 *Risks with the re-identification of de-identified data and general ethical concerns*

40
 41 There are significant ethical concerns about the disclosure and use of de-identified health data that
 42 are rooted in the risk of re-identification. Studies have shown that certain elements of patient
 43 records, although not exclusive or unique to individual patients, increase the risk of re-
 44 identification if not removed from individual-level data.^{29,30} Elements such as gender, date of
 45 service, date of birth or zip code can potentially be linked back to other sources of data, such as
 46 voter registration lists, and could put the data at risk of re-identification.^{31,32} Organizations that
 47 collect, store, transfer and distribute de-identified data should take steps to reduce this risk, such as
 48 replacing a specific date of birth or date of service with a year.

49
 50 Additionally, studies assessing the risk of re-identification after attempts to de-identify the data
 51 have found that just a few attributes are often enough to render the likelihood of correct re-

identification very high. Our AMA policy is clear that the re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity. Furthermore, since our initial Board report was presented during A-19, new studies and legal challenges have emerged that provide additional insight, and by extension raise additional concerns, about the increasing ability of entities (especially those with augmented intelligence (AI) capabilities) to re-identify de-identified patient data.^{33,34,35} Our AMA believes that corporate entities have a responsibility and an obligation to ensure that technical safeguards are being used to prevent the re-identification of de-identified patient data.

In addition to risk of re-identification, there are general ethical concerns with the availability and use of patient health data, even if it is de-identified, without explicit authorization from patients. For example, pharmaceutical companies may use de-identified data to target marketing or advertising efforts to specific physicians, therefore influencing treatment plans for patient populations with specific diseases or conditions. Accountable Care Organizations (ACOs), as business associates of the ACO participants or a covered entity, may use de-identified data to analyze quality measures, population risk scores and patient behaviors.³⁶ Other for-profit entities may use de-identified data for the development of new technology or clinical innovations. These sales of patient records for profit by provider organizations may raise concerns from the public that providers have an ulterior motive for collecting their data during clinical encounters. There are also studies demonstrating that for-profit entities selling de-identified information gleaned from consumer-facing mobile health applications (apps) frequently are in violation of the apps' stated privacy policies.³⁷ In addition, patient record licensing contracts with exclusive rights may raise questions about the appropriate stewardship of patient data, as such exclusive contracts may be seen to benefit specific licensees at the expense of others, rather than enabling research and product development across the entire marketplace. However, one can imagine limited scenarios where a registry may choose to license de-identified data sets to commercial entities, with or without some degree of exclusivity, and yet maintain proper safeguards that require entities to ensure the data is not re-identified so the data can be used to further medical research.

Consent and authorization

Issues that arise in the potential risks of patient data use can be mitigated by proactively obtaining appropriate authorization or informed consent from patients for the use of their data. In the context of HIPAA, these issues primarily apply to PHI and not de-identified data. The HIPAA Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of PHI for TPO. Covered entities that decide to obtain consent have complete discretion to design a process that best suits their needs. By contrast, an authorization is required by the Privacy Rule for most uses and disclosures of PHI not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of PHI. An authorization is a detailed document that gives covered entities permission to use PHI for specified purposes (e.g., sale of PHI or use of PHI to conduct marketing activities) or to disclose PHI to a third party specified by the individual. An authorization must include a number of elements, including a description of the PHI to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed.³⁸

PHI may be used and disclosed for research without an authorization in limited circumstances: (1) under a waiver of the authorization requirement; (2) as a limited data set with a data use agreement; (3) preparatory to research; and (4) for research on decedents' information. Limited data sets exclude 16 categories of direct identifiers, rather than the 18 identifiers removed in de-

1 identified data. The information in a limited data set is considered PHI and its use or disclosure
2 requires a data use agreement between the covered entity and the entity that will receive or use the
3 data.

4 5 *Standards and guidance*

6
7 ONC publishes the “Guide to Privacy and Security of Electronic Health Information” to help
8 physicians, other health care providers and practices work to comply with federal requirements in
9 collecting, storing and using patients’ data.³⁹

10
11 In addition to the policy set by the AMA and the guidance provided in the AMA *Code of Medical*
12 *Ethics*, other physician and health care organizations provide guidelines and standards on the use of
13 de-identified patient data. For example, the American Academy of Family Physicians published a
14 “Data Stewardship” policy that facilitates the appropriate collection, storage, transmission,
15 analysis, and reporting of de-identified patient data.⁴⁰ This policy includes guidance on establishing
16 and maintaining a proper patient and physician consent process, as well as the appropriate use of
17 data by third parties and policies that establish requirements for third-party use.

18
19 The American College of Physicians (ACP) policy encourages clinical entities and physicians to
20 publish electronically their policies and procedures for sharing patient data and ensuring privacy.
21 ACP’s policy also states that in keeping with HIPAA, patients should know what information
22 exists about them, its purpose, who can access and use it, and where it resides. While ACP supports
23 the use of appropriately de-identified patient data for socially important activities, such as
24 population health efforts and retrospective research, it does recommend tighter controls on the risks
25 of re-identification of de-identified data.⁴¹

26 27 CONCLUSION

28
29 Access to de-identified patient data is important for the future of health care. Its benefits to the field
30 of research have significant implications for our ability to make progress in refining the practice of
31 medicine, reducing health care costs, reducing and preventing chronic disease, identifying cures for
32 deadly conditions, and much more. In practice-level interventions, de-identified data can help
33 practice administrators recognize patterns and gaps in processes and treatment plans across
34 clinicians. Although the use of de-identified patient data can contribute to the continuum of
35 improvement that is much needed across health care, its use comes with significant risks in the area
36 of re-identifying patient data. The use of patient data is rapidly evolving, and our AMA must
37 remain vigilant to ensure patient data is being used properly, that appropriate safeguards are
38 instituted to ensure risks are mitigated, and that, where patient consent is required or warranted, it
39 is meaningful.

40 41 RECOMMENDATIONS

42
43 The Board of Trustees recommends that the following be adopted and the remainder of this report
44 be filed:

- 45
46 1. That our American Medical Association (AMA) reaffirm Policies H-315.975, “Police, Payer,
47 and Government Access to Patient Health Information,” H-315.978, “Privacy and
48 Confidentiality,” and H-315.987, “Limiting Access to Medical Records.” (Reaffirm HOD
49 Policy)

- 1 2. That our AMA adopt a technical change to Policy H-315.974, “Guiding Principles, Collection
2 and Warehousing of Electronic Medical Record Information,” by addition as follows: (Modify
3 Current HOD Policy)
4
5 Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical
6 Record Information”
7 Our AMA expressly advocates for physician ownership of all claims data, transactional data
8 and de-identified and/or aggregate data created, established and maintained by a physician
9 practice, regardless of how and where such data is stored but specifically including any such
10 data derived from a physician's medical records, electronic health records, or practice
11 management system, while preserving the principle that physicians act as trusted stewards of
12 Protected Health Information.
13
14 3. That our AMA support efforts to promote transparency in the use of de-identified patient data
15 and to protect patient privacy by developing methods of, and technologies for, de-identification
16 of patient information that reduce the risk of re-identification of such information. (New HOD
17 Policy)
18
19 4. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance
20 relevant to the confidentiality of patient information, striving to preserve the benefits of
21 widespread use of de-identified patient data for purposes of promoting quality improvement,
22 research, and public health while mitigating the risks of re-identification of such data.
23 (Directive to Take Action)
24
25 5. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be
26 rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: Less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-N-21

Subject: Further Action on Bylaw 7.5.2

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

At the June 2021 meeting of the AMA House of Delegates, the House adopted two reports from the Council on Constitution and Bylaws related to eligibility for the Young Physicians Section. CCB Report 3-JUN-21 provided language to clarify original Bylaw 7.5.2 as follows:

7.5 Young Physicians Section. The Young Physicians Section is a fixed section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 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 any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

In consultation with the Young Physicians Section, CCB issued Report 5-JUN-21, which further amended the language of 7.5.2 as follows, and which also was adopted by the House:

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes last.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 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 any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting following that when in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect through the end of the chair role, or 2nd year. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

In reconciling the language of the two reports for PolicyFinder and the July 2021 update of the AMA Bylaws, it was discovered that that the words "in the calendar year" of 7.5.2 were inadvertently omitted from CCB Report 5-JUN-21. While elimination of these words was the goal of the YPS and CCB, because the words were not shown as stricken the words remain in the July 2021 Bylaws.

The Council has prepared this report to present the appropriate bylaw amendment by deletion to ensure that the AMA Constitution and Bylaws remains an accurate document. The Council confirmed with the Young Physicians Section that deletion of these words was the intent of both groups.

RECOMMENDATIONS

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

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes last.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 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 any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year following that

1 when such member ceases to meet the membership requirements of Bylaw 7.5.1, as
2 long as the member remains an active physician member of the AMA.

3
4 **7.5.2.1** The chair position is a three-year commitment and divided into the roles of
5 chair-elect, chair, and immediate past chair. The young physician must meet
6 the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The
7 chair-elect, chair and immediate past chair shall be granted membership in the
8 Section and be permitted to complete the term of office even if unable to
9 continue to meet all of the requirements of Bylaw 7.5.1, as long as the
10 physician remains an active physician member of the AMA.

11
12 (Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-N-21

Subject: Rescission of Bylaws Related to Run-off Elections

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

At the June 2021 meeting of the AMA House of Delegates, the House adopted Recommendation 30 of Speakers Report 2, "Report of the Election Task Force," recommending that Bylaws 3.4.2.2 and 6.8.1.5 be rescinded. Rescission of these bylaw provisions and implementation of G-610.030, whereby voting for all elected positions including runoffs will be conducted electronically during an Election Session, encourages candidates to announce their candidacy early, adds transparency to AMA elections, results in more contested elections, allows delegations the opportunity to vet candidates for newly opened positions, and eliminates the distraction from policy discussion that occurs with the prior "pop-up" process as G-610.030 eliminates "pop-ups."

The Council has prepared this report to present the appropriate bylaw amendments for House action.

RECOMMENDATIONS

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

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.2 ~~At Large Trustees to be Elected to Fill Vacancies after a Prior Ballot.~~ The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4 year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

[Subsequent bylaw provisions will be renumbered accordingly.]

1 **6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council**
2 **on Medical Service, and Council on Science and Public Health.**

3
4 ***

5 **6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The
6 nomination and election of members of the Council to fill a vacancy that did
7 not exist at the time of the prior ballot shall be held after election of other
8 members of the Council, and shall follow the same procedure. Individuals
9 elected to such vacancy shall be elected to a complete 4 year term.
10 Unsuccessful candidates in the election for members of the Council shall
11 automatically be nominated for subsequent elections to fill any such vacancy
12 until all members of the Council have been elected. In addition, nominations
13 from the floor shall be accepted.

14
15 (Modify Bylaws)

RELEVANT AMA POLICY

G-610.030, Election Process. AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker; (3) All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes; and (4) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-N-21

Subject: AMA Women Physicians Section: Clarification of Bylaw Language

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the June 2021 meeting, the Council submitted a report at the request of the Women Physicians
2 Section to clarify the membership of the Women Physicians Section (WPS). CCB Report 2, “AMA
3 Women Physicians Section: Clarification of Bylaw Language,” proposed bylaw amendments to
4 specify that all female physician and medical student members of the AMA as identified in the
5 AMA Masterfile would automatically be considered WPS members in contrast to existing bylaw
6 language that declares them “eligible” for WPS membership. Existing bylaw language also states
7 that “other active AMA members who express an interest in women’s issues shall be eligible for
8 WPS membership.” The Council’s proposed language was consistent with the Internal Operating
9 Procedures of the WPS review by the Council and approved by the Board.

10
11 Reference committee testimony on CCB Report supported the automatic inclusion of female
12 physicians and medical students as WPS members, but some concerns arose about the need for
13 gender-neutral language that ensured equal access to the WPS regardless of gender identity. The
14 reference committee proposed alternative language as follows: “All physicians and medical
15 students who are active members of the AMA and identify as female shall be members of the
16 Women Physicians Section. Other active members of the AMA who express an interest in
17 women’s issues shall be eligible to join the section.” The House did not accept the amended
18 language offered by the reference committee and the report was referred back.

19 20 BACKGROUND

21
22 The Council has investigated how various AMA databases categorize gender to better understand
23 the process of gender self-identification and implications for WPS membership. The Council
24 learned that the AMA Masterfile is used to identify gender (male, female or unknown) for purposes
25 of section participation. The Masterfile, established in 1906, derives its basic information for U.S.
26 allopathic students and physicians from the Association of American Medical Colleges (AAMC)
27 and their work with Liaison Committee on Medical Education (LCME) accredited medical schools.

28
29 When an individual enters an LCME accredited medical school, the AMA creates a record for that
30 individual. The initial record created with AAMC matriculation data includes legal name, date of
31 birth, birthplace, legal residence, gender (male or female), and training institution.¹ Specifically,
32 gender information is self-reported by the individual on their medical school application.
33 International medical graduates (IMGs) are identified upon entry into an ACGME-accredited post-
34 graduate residency training program or when they obtain a license in a US licensing jurisdiction.

¹ Per Policy D-630.972, our AMA continues to work with the AAMC to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.

U.S. osteopathic students and physicians are entered after verifying enrollment in or graduation from an accredited osteopathic medical school. Gender is provided, where available, by the school as part of the verification process. As a physician's training and career develop, additional information, such as licensure, residencies, fellowships, board certification and recertification, and type of practice, is added to their record. Records are continuously updated through extensive data collection and verification efforts. The Masterfile not only serves as a primary resource for professional medical organizations, universities and medical schools, research institutions, governmental agencies and other health-related groups, but its use is fundamental to the AMA's mission to strengthen the medical profession and ensure quality health care for the American public.

In 2018, AMA established a separate database to collect and maintain information on gender identity and sexual orientation in response to the adoption of Policy G-635.125, "AMA Membership Demographics." Submission of information to the Sexual Orientation Gender Identity (SOGI) database is completely voluntary and confidential. To protect confidentiality, these data are only provided in aggregate for the AMA to better understand its membership demographics and are not made available at the physician level for any purpose. As of August 2021, approximately 35,000 physicians have chosen to provide this information via the AMA Account Management Center.

Updates to the AMA Physician Masterfile can be submitted electronically through the AMA Account Management Center, or the Online Data Collection Center at <https://login.ama-assn.org/account/login>. Updates can also be mailed or faxed to the AMA, Division of Health Solutions Data Management, Attn: Data Verification Unit, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, Illinois 60611, (312) 464-5759, (312) 464-4880 (Fax). Physicians can also update information on their Masterfile record by contacting the AMA Member Service Center at 800-262-3211 (available Monday through Friday from 8:00 AM until 5:00 PM CT).

While the Council supports the desire of WPS to allow those physicians who self-identify as female to be enrolled automatically as WPS members based on either Masterfile or SOGI data, that cannot currently be accomplished without violating the confidentiality under which these data were collected. The only way to ensure that the WPS offers equal access to the section regardless of gender identity would be to make the WPS an opt-in section, which likely would significantly diminish its membership numbers and impact.

The Council on Constitution and Bylaws presents this report for House action.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.

7.10.1 Membership. All female physicians and ~~female~~ medical students who are active members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express an interest in women's issues may also ~~shall be eligible to~~ join the section. (Modify Bylaws)

Fiscal Note: Less than \$500

RELEVANT AMA POLICY

G-635.125, AMA Membership Demographics

1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

D-630.972, AMA Race/Ethnicity Data

Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.

H-65.9671, Conforming Sex and Gender Designation on Government IDs and Other Documents

1. Our AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.
5. Our AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-N-21

Subject: Short-term Medical Service Trips

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills. At the same time, short-term medical service trips pose challenges for everyone involved. Volunteers, sponsors, and hosts must jointly prioritize activities to meet agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting.

This report by the Council on Ethical and Judicial Affairs (CEJA) explores the phenomenon of short-term medical service trips and offers guidance for physicians and physicians in training to help them address the ethical challenges they face in providing clinical care in resource-limited settings abroad.

THE APPEAL OF SERVING ABROAD

Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically related [1]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [2]. The Association of American Medical Colleges found that among students who graduated in 2017–2018 between 25% and 31% reported having had some “global health experience” during medical school [3].

A variety of reasons motivate physicians and trainees to volunteer for service trips. For many, compelling motivations include the opportunities such trips offer to help address health inequities, to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic of study [1]. Service trips can also serve less lofty goals of building one's resume and improving one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [1].

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A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including “short-term medical volunteerism” [4], “short-term medical missions” [5], “short-term medical service trips” [6,7], “short-term experience in global health” [8,9], “global health field experience” [10], “global health experience,” and “international health experience”[1]. Each has merit as a term of art.

The Council on Ethical and Judicial Affairs prefers “short-term medical service trips.” In the council’s view, this term is clear, concrete, concise, and does not lend itself to multiple interpretations and possible misunderstanding. Importantly, it succinctly captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [9]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [8]. Many now also offer training opportunities for medical students and residents [8,9,10]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [8,9].

The medical needs of host communities differ from those of volunteers’ home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by “conditions, such as severe malnutrition, for which medical volunteers may have limited experience” [6]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are “victims of social, economic, or environmental factors” who have limited access to health care [6], and often lack access to food, and economic and political power as well and “may feel unable to say no to charity in any form offered” [9]. Moreover, short-term medical service trips take place under the long shadow of colonialism, including medicine’s role [11], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [9,12,13].

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties to maximize and enhance good clinical outcomes, to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [1,8, 9,10].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [8,6]. Trips should seek to balance community priorities with the training interests and abilities of participants [9], but in the first instance benefits should be those desired by the host community [8]. Likewise, interventions must be acceptable to the community [8].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [6]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [6,9].

Minimizing Potential for Harms & Burdens in Host Communities

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips could place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [8], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [8,10]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [6].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [10]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [10].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [1,8]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the

expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local “explanatory models” of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community [6,9,10].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [10], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities’ cultural and social traditions does *not* obligate physicians and trainees “to violate fundamental personal values, standards of medical care or ethical practice, or the law” [8]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [14]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [15].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip’s overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [1,8,9,10].

Prepare Diligently

Guidelines from the American College of Physicians recognize that “predeparture preparation is itself an ethical obligation” [8,cf. 1]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [10].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who

1 have “training and/or familiarity with principles of international development, social determinants
2 of health, and public health systems” [9].

3
4 Adequately preparing physicians and trainees for short-term medical service trips encompasses
5 planning with respect to issues of personal safety, vaccinations, unique personal health needs,
6 travel, malpractice insurance, and local credentialing requirements [6]. Equally important, to
7 contribute effectively and minimize “culture shock” and distress, volunteers need a basic
8 understanding of the context in which they will be working [1,6]. Without expecting them to
9 become experts in local culture, volunteers should have access to resources that will orient them to
10 the language(s), traditions, norms, and expectations of the host community, not simply to the
11 resource and clinical challenges they are likely to face. Volunteers should have sufficient
12 knowledge to conduct themselves appropriately in the field setting, whether that is in how they
13 dress, how they address or interact with different members of the community, or how they carry
14 out their clinical responsibilities [6]. And they need to know whom they can turn to for guidance in
15 the moment.

16
17 Preparation should also include explicit attention to the possibility that volunteers will encounter
18 ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real
19 possibility for physicians and trainees that they will encounter situations in which they “are unable
20 to act in ways that are consistent with ethics and their professional values” or “feel complicit in a
21 moral wrong” [8]. Having strategies in place to address dilemmas when they arise and to debrief
22 after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with
23 local norms, volunteers may withdraw from care of an individual patient or from the mission after
24 careful consideration of the effect withdrawing will have on the patient, the medical team, and the
25 mission overall, in keeping with ethics guidance on the exercise of conscience.

26 27 *Choose Thoughtfully*

28
29 Individual physicians and trainees who volunteer for short-term medical service trips are not in a
30 position to directly influence how such programs are organized or carried out. They can, however,
31 by preference choose to participate in activities carried out by organizations that fulfill the ethical
32 responsibilities discussed above [8,9,10]. Volunteers can select organizations and programs that
33 demonstrate commitment to long-term, community-led efforts to build and sustain local health care
34 resources over programs that provide episodic, stop-gap medical interventions, which can promote
35 dependence on the cycle of foreign charitable assistance rather than development of local
36 infrastructure [9].

37 38 *Measure & Share Meaningful Outcomes*

39
40 Organizations that sponsor short-term medical service trips have a responsibility to monitor and
41 evaluate the effectiveness of their programs, [8,6,9]. The measures used to evaluate program
42 outcomes should be appropriate to the program’s goals as defined proactively in collaboration with
43 the host community [8]; for example, some have suggested quality-adjusted life years (QALYs)
44 [16]. Prospective participants should affiliate themselves with programs that demonstrate
45 effectiveness in providing outcomes meaningful to the population they serve, rather than simple
46 measures of process such as number of procedures performed [6]. Developing meaningful outcome
47 measures will require thoughtful reflection on the knowledge and skills needed to address the
48 specific situation of the community or communities being served and on what preparations are
49 essential to maximize health benefits and avoid undue harm.

RECOMMENDATION

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent response for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

- (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.
- (b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.
- (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

1 Sponsors of short-term medical service trips should:

2
3 (d) Ensure that resources needed to meet the defined goals of the trip will be in place,
4 particularly resources that cannot be assured locally.

5
6 (e) Proactively define appropriate roles and permissible range of practice for members of the
7 volunteer team, including the training, experience, and oversight of team members required
8 to provide acceptable safe, high-quality care in the host setting. Team members should
9 practice only within the limits of their training and skills in keeping with the professional
10 standards of the sponsor's country.

11
12 (f) Put in place a mechanism to collect data on success in meeting collaboratively defined
13 goals for the trip in keeping with recognized standards for the conduct of health services
14 research and quality improvement activities in the sponsor's country.

15
16 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-N-21

Subject: Amendments to Opinions 1.2.11, “Ethical Innovation in Medical Practice”;
11.1.2, “Physician Stewardship of Health Care Resources”; 11.2.1,
“Professionalism in Health Care Systems”; and 1.1.6, “Quality”

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 As the Council on Ethical and Judicial Affairs noted in its recent informational report on
2 augmented intelligence (AI) in medicine:

3
4 AI systems represent the latest in a long history of innovations in medicine. Like many new
5 technologies before them, AI-based innovations challenge how physicians practice and how
6 they interact with patients at the same time that these innovations offer promises to promote
7 medicine’s Quadruple Aim of enhancing patient experience, improving population health,
8 reducing cost, and improving the work life of health care professionals [1].
9

10 At the same time, several characteristics distinguish AI-enabled innovations from other innovations
11 in medicine in important ways. The data-driven machine-learning algorithms that drive clinical AI
12 systems have the potential to replicate bias in the data sets on which they are built and exacerbate
13 inequities in quality of care and patient outcomes. The most powerful, and useful, models are
14 “black boxes” that have the capacity to evolve outside of human observation and independent of
15 human control. Moreover, the design, development, deployment, and oversight diffuse
16 accountability over multiple stakeholders who have differing forms of expertise, understandings of
17 professionalism, and diverging goals.
18

19 Published analyses of ethical challenges presented by AI in multiple domains have converged
20 around a core set of goals [2,3,4]:
21

- 22 • Protecting the privacy of data subjects and the confidentiality of personal information
- 23 • Ensuring that AI systems are safe for their intended use(s)
- 24 • Designing systems of accountability that are sensitive to the roles different stakeholders
25 play in the design, deployment, performance, and outcomes of AI systems
- 26 • Maximizing the transparency and explainability of AI systems
- 27 • Promoting justice and fairness in the implementation and outcomes of AI systems
- 28 • Maintaining meaningful human control of AI technologies
- 29 • Accommodating human agency in AI-supported decision making/the use of AI
30

31 Realizing these goals for any AI system, in medicine or other domains, will be challenging. As the
32 Gradient Institute notes in its report, Practical Challenge for Ethical AI, AI systems “possess no

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intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions” [5]. Developers must devise mathematical expressions for concepts such as “fairness” and “justice” and specify acceptable balances among competing objectives that will enable an algorithm to approximate human moral reasoning. They must design systems in ways that will align the consequences of the system’s actions with the ethical motivation for deploying the system. And oversight must meaningfully address “the problem of many hands” in ascribing responsibility with respect to AI systems [6].

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

Policies adopted by the AMA House of Delegates address issues of thoughtful AI design ([H-480.940](#), “Augmented Intelligence in Health Care”) and matters of oversight, payment and coverage, and liability ([H-480.939](#)). Policy [H-295.857](#) addresses issues of AI in relation to medical education. AMA has further developed a framework for trustworthy AI in medicine that speaks broadly to the primacy of ethics, evidence, and equity as guiding considerations for the design and deployment of AI systems in health care and the interplay of responsibilities among multiple stakeholders [7].

The introduction of AI systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA *Code of Medical Ethics*. These include quality of care, innovation in medical practice, stewardship of health care resources, and professionalism in health care systems, as well as privacy.

The *Code* grounds the professional ethical responsibilities of physicians in medicine’s fundamental commitment of fidelity to patients. As [Opinion 1.1.1](#) notes:

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

From the perspective of professional ethics, securing this commitment should equally inform medicine’s response to emerging AI-enabled tools for clinical care and health care operations.

Guidance in [Opinion 1.2.11](#), “Ethical Innovation in Medical Practice,” calls on individuals who design and deploy innovations to ensure that they uphold the commitment to fidelity by serving the goals of medicine as a priority. It directs innovators to ensure that their work is scientifically well grounded and prioritizes the interests of patients over the interests of other stakeholders. Opinion 1.2.11 further recognizes that ensuring ethical practice in the design and introduction of innovations does not, indeed cannot, rest with physicians alone; health care institutions and the profession have significant responsibilities to uphold medicine’s defining commitment to patients.

[Opinion 11.2.1](#), “Professionalism in Health Care Systems,” defines the responsibilities of leaders in health care systems to promote physician professionalism and to ensure that mechanisms adopted to influence physician decision making are “designed in keeping with sound principles and solid scientific evidence,” deployed fairly so that they “do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities.” It similarly recognizes that institutional

leaders should ensure that when these mechanisms are deployed they are monitored to identify and respond to the effects they have on patient care.

Individual physicians, and the institutions within in which they practice, have a responsibility to be prudent stewards of the shared societal resources entrusted to them, addressed in [Opinion 11.1.2](#), “Physician Stewardship of Health Care Resources.” Even as they prioritize the needs and welfare of their individual patients, physicians have a responsibility to promote public health and access to care. They fulfill that responsibility by choosing the course of action that will achieve the individual patient’s goals for care in the least resource intensive way feasible.

Finally, as [Opinion 1.1.6](#), “Quality,” directs, all physicians share a responsibility for promoting and providing care that is “safe, effective, patient centered, timely, efficient, and equitable.” This should be understood to include a responsibility to adopt AI systems that have been demonstrated to improve quality of care and patients’ experience of care.

For the most part, individual physicians will be consumers of AI systems developed by others. As individual end users, physicians cannot reasonably be expected to have the requisite expertise or opportunity to evaluate AI systems. They must rely on their institutions, or the vendors from whom they purchase AI systems, to ensure that those systems are trustworthy.

Nonetheless, physicians do have an important role to play in promoting fair, responsible use of well-designed AI systems in keeping with responsibilities already delineated in the AMA *Code of Medical Ethics* noted above. Their voice must be heard in helping to hold other stakeholders accountable for ensuring that AI systems, like other tools, support the goals and values that define the medical profession and to which individual practitioners are held. CEJA Report 4-JUN-21 outlines the kinds of assurances physicians should be able to expect from their institutions when a given AI system is proposed or implemented.

CONCLUSION

AI systems are already a fact of life in medicine and other domains; it would be naïve to imagine there will not be further rapid evolution of these technologies. Fidelity to patients requires that physicians recognize the ways in which AI systems can improve outcomes for their patients and the community and enhance their own practices. They should be willing to be reflective, critical consumers of well-designed AI systems, recognizing both the potential benefits and the potential downsides of using AI-enabled tools to deliver clinical care or organize their practices.

The fact that existing guidance in the AMA *Code of Medical Ethics* already addresses fundamental issues of concern noted above, coupled with the pace and scope of continuing evolution of AI technologies, the council concludes that developing guidance specifically addressing augmented intelligence in health care is not the most effective response. Rather, the council believes that amending existing guidance to more clearly encompass AI will best serve physicians and the patients they care for.

As the council noted in CEJA Report 4-JUN-21, the implications of AI technologies, and more specifically, the exploitation of “big data” to drive improvements in health care, carries significant implications for patient privacy and confidentiality that warrant separate consideration. The council intends to address those implications separately in future deliberations.

RECOMMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, “Ethically Sound Innovation in Medical Practice”; Opinion 11.2.1, “Professionalism in Health Care Systems”; Opinion 11.1.2, “Physician Stewardship of Health Care Resources”; and Opinion 1.1.6, “Quality,” be amended as follows and the remainder of this report be filed:

1. Opinion 1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can span a wide range of activities. ~~From~~ It encompasses not only improving an existing intervention, to introducing an innovation in one’s own clinical practice for the first time, to using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, and or interventions they offer to patients employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.
- (d) Be sensitive to the cost implications of innovation.
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

- (f) Base recommendations on patients’ medical needs.
- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills.
- (h) Recognize that in this context informed decision making requires the physician to disclose:
 - (i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

- 1 (ii) why the physician is recommending the innovative modality;
2
3 (iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy
4 and alternatives are;
5
6 (iv) what experience the professional community in general and the physician individually
7 has had to date with the innovative therapy;
8
9 (v) what conflicts of interest the physician may have with respect to the recommended
10 therapy.
11
12 (i) Discontinue any innovative therapies that are not benefiting the patient.
13
14 (j) Be transparent and share findings from their use of innovative therapies with peers in some
15 manner. To promote patient safety and quality, physicians should share both immediate or
16 delayed positive and negative outcomes.
17
18 To promote responsible innovation, health care institutions and the medical profession should:
19
20 (k) Ensure that innovative practices or technologies that are made available to physicians meet
21 the highest standards for scientifically sound design and clinical value.
22
23 (kl) Require that physicians who adopt ~~innovative treatment or diagnostic techniques~~
24 innovations into their practice have ~~appropriate~~ relevant knowledge and skills.
25
26 (lm) Provide meaningful professional oversight of innovation in patient care.
27
28 (mn) Encourage physician-innovators to collect and share information about the resources
29 needed to implement their ~~innovative therapies~~ innovations safely, effectively, and
30 equitably.
31

32 2. Opinion 11.2.1, Professionalism in Health Care Systems

33
34 Containing costs, promoting high-quality care for all patients, and sustaining physician
35 professionalism are important goals. Models for financing and organizing the delivery of health
36 care services often aim to promote patient safety and to improve quality and efficiency.
37 However, they can also pose ethical challenges for physicians that could undermine the trust
38 essential to patient-physician relationships.
39

40 Payment models and financial incentives can create conflicts of interest among patients, health
41 care organizations, and physicians. They can encourage undertreatment and overtreatment, as
42 well as dictate goals that are not individualized for the particular patient.
43

44 Structures that influence where and by whom care is delivered—such as accountable care
45 organizations, group practices, health maintenance organizations, and other entities that may
46 emerge in the future—can affect patients' choices, the patient-physician relationship, and
47 physicians' relationships with fellow health care professionals.
48

49 Formularies, clinical practice guidelines, decision support tools that rely on augmented
50 intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge

on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should ensure that practices for financing and organizing the delivery of care:

(a) Ensure that decisions to implement practices or tools for organizing the delivery of care
are transparent and reflect input from key stakeholders, including physicians and patients.

~~(b) Reflect input from key stakeholders, including physicians and patients.~~

(eb) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.

(ec) Ensure ~~ethically acceptable incentives~~ that all such tools:

(i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(ed) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(fe) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(gf) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to:

- (i) identify and address adverse consequences;
- (ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(hg) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(ih) ~~Advocate for changes in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients.

3. Opinion 11.1.2, Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

- (a) Base recommendations and decisions on patients' medical needs.
- (b) Use scientifically grounded evidence to inform professional decisions when available.
- (c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
- (d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.
- (e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
- (f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
- (g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

- (h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
- (i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.
- (j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.
- (k) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

4. Opinion 1.1.6, Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- (a) Keeping current with best care practices and maintaining professional competence.
- (b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (c) Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.
- (d) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

(Modify HOD/CEJA policy)

Fiscal Note: Less than \$500

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REPORT OF THE SPEAKERS

Speakers' Report 1-N-21

Subject: Report of the Election Task Force
(Recommendation 16, Speakers' Report 2-JUN-21)

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the June 2021 Special Meeting, the report of the Election Task Force (Speakers' Report 2)
2 substantially revised the rules regarding nominations and elections. (See the updated policy in the
3 appendix.) The following recommendation, dealing with interviews, was referred with a request for
4 more detail.

5
6 Delegations and caucuses may conduct interviews by virtual means in advance of the Annual
7 Meeting of the House of Delegates during a period of time to be determined by the Speaker in
8 lieu of in-person interviews at the meeting. Delegations and caucuses may choose either
9 method, but not both for a given race. Groups electing to interview candidates for a given
10 position must provide an equal opportunity for all candidates for that position who have
11 announced their intention to be nominated at the time interviews are scheduled, to be
12 interviewed using the same format and platform. An exception being that a group may elect to
13 meet with a candidate who is from their own delegation without interviewing other candidates.
14 Recording of virtual interviews must be disclosed to candidates prior to recording and may
15 only be recorded with candidate consent. Interview recordings may only be shared with
16 members of the interviewing caucus/group.

17
18 Testimony was generally supportive of continuing the option of virtual interviews and most of the
19 details provided in the recommendation, but concerns were expressed regarding the lack of
20 specificity of the interview time period. Such matters as excessive demands on candidates, time
21 zone differences between interviewers and interviewees, and interference with clinical duties
22 underlay the referral. This report provides recommendations for the conduct of virtual interviews,
23 proposing limits and expectations for fairness.

24 25 BACKGROUND

26
27 Interviews are generally regarded as the best tool by which to measure candidates and select those
28 for whom one will vote. As both the 2020 and 2021 Annual Meetings were cancelled due to
29 COVID, the speakers recorded interviews with candidates and made them available through the
30 AMA website. The speakers also laid out rules to facilitate virtual interviews with candidates that
31 were conducted by various caucuses and delegations.

32
33 The virtual interviews were viewed favorably and not simply as substitutes for the in-person
34 interviews typically conducted during the Annual Meeting. The Task Force report recommended
35 continuation of the virtual interviews as an option even after return to in-person meetings, and

1 comments during this past June's special meeting supported the use of virtual interviews by
2 delegations provided a standard set of rules could be implemented.

3 4 PROPOSALS FOR VIRTUAL INTERVIEWS

5
6 The Task Force had proposed that all interviews by a delegation or caucus for a given office be
7 conducted by the same means: either in-person (onsite at the Annual Meeting) or virtually, before
8 arriving in Chicago for the Annual Meeting. This was done in the interest of fairness, and as no
9 comments were heard on this topic, the recommendation will be retained. Delegations and caucuses
10 should continue to be allowed to select the method of interviews that best suits their needs.

11
12 During testimony at the June 2021 Special Meeting concerns were raised regarding the days and
13 times during which virtual interviews may be conducted. The referred recommendation stated that
14 virtual interviews would be conducted "during a period of time to be determined by the Speaker."
15 Comments were heard that virtual interviews conducted before the June 2020 and June 2021
16 Special Meetings were spread over too long a period of time, that the dates were not known in
17 advance and that some interview times interfered with clinical duties particularly for those in the
18 Pacific and Eastern time zones. To address these concerns your speakers recommend a defined,
19 relatively short window of dates for virtual interviews and interview times to be scheduled outside
20 regular clinical hours. Meanwhile in-person interviews at the meeting will continue to be an option.

21
22 To allow candidates and delegations to plan, a specific window of dates should be defined. Both
23 candidates and interviewers expressed a preference for interview dates relatively close to the
24 opening of the Annual Meeting including the option of weekend interviews. Interviews should not
25 be conducted the week immediately preceding the meeting which is typically busy with other
26 responsibilities, including section and council meetings along with travel. Therefore, the window
27 for virtual interviews is recommended to begin on the Friday evening of the second weekend
28 immediately preceding the scheduled opening session of the House of Delegates meeting at which
29 elections will take place and end on the Sunday evening of the weekend immediately preceding the
30 meeting. Virtual interviews may only be scheduled during this defined period, beginning 15 days
31 before and ending six days before the meeting opens. This window includes two weekends and six
32 weeknights.¹ Should a planned in-person meeting be cancelled, the window could open a week
33 earlier, effectively doubling the time available for interviews. Discretion should be granted to the
34 speaker to address special situations such as this.

35
36 To avoid interfering with candidates' professional responsibilities, especially patient care and
37 related clinical duties, interviews conducted on a weeknight (ie, Monday through Friday) must be
38 scheduled between 5 pm and 10 pm based on the candidate's (ie, the person being interviewed)
39 local time. Interviews conducted on weekends must be scheduled between 8 am and 10 pm based
40 on the candidate's local time. Recognizing that physicians often have clinical duties outside of
41 regular business hours, candidates and interviewers are encouraged to be flexible in scheduling
42 interviews. Other times outside of these hours must be acceptable to both parties. Caucuses and
43 delegations scheduling interviews for candidates within the parameters above are not obligated to
44 offer alternatives but are encouraged to do so if possible. Candidates are encouraged to make
45 themselves available for these interview windows to the extent possible but are entitled to decline
46 any interview request.

¹ For example, the 2021 Annual Meeting was scheduled to begin on Saturday, June 12, which means the interviewing window would have run from the evening of Friday, May 28 through Sunday, June 6.

1 The Office of House of Delegates Affairs compiles candidate contact information, including that
2 for the candidate's campaign team. The information will be provided to groups wishing to
3 interview candidates. Groups wishing to conduct interviews must designate their interviewing
4 coordinator and provide the individual's contact information to the Office of House of Delegates
5 Affairs. This list will then be shared with all declared candidates. It is incumbent on the candidates
6 to schedule their individual interviews. The Office of House of Delegates Affairs will continue to
7 create an interview schedule for officer candidates in opposed races for those regional caucuses and
8 sections electing to interview in-person.

9
10 Policy G-610.020 sets clear guardrails around announcements of candidacy, meaning candidate
11 contact information will be available well before the interviewing window opens. While interviews
12 may not be conducted outside the window, interviewers will be allowed to contact candidates to set
13 up interviews any time after the publication of the election manual, typically in mid-April.

14
15 *Other relevant elements for interviews*

16
17 The referred language includes additional elements that merit discussion, namely the format and
18 platform used, the recording of interviews, and the sharing of those recordings. None of these items
19 drew criticism at June's meeting.

20
21 A foundational concept for the Task Force was to provide a level playing field for all candidates.
22 Seeking to ensure fairness, the Task Force recommended that all candidates for a given office be
23 interviewed using the same format, so all candidates for a given office must be interviewed either
24 in-person or virtually. Interviewers are free to use either modality, with candidates for some offices
25 interviewed online and candidates for other offices interviewed onsite, but the chosen modality
26 applies to all candidates for a given office. To be clear, an interviewing group is also free to use
27 only virtual or only in-person interviews for all candidates. All virtual interviews for a given office
28 must also be conducted on the same or similar platform, for example, all audio only or by video
29 with audio. The choice of platform to be used should be confirmed when an interview is arranged;
30 flexibility to accommodate availability of specific platforms (Teams, Zoom, etc.) is encouraged.

31
32 Recognizing that delegations have a special relationship with their own members who may be
33 candidates, the Task Force proposed an exception to the requirement to interview all candidates for
34 a particular office. This exception allows the interviewing group to meet with a candidate who is a
35 member of their group without interviewing other candidates for the same office. No objections
36 were raised during testimony, and this exception is recommended to be retained.

37
38 Questions have been raised regarding what constitutes an interview and what does not. This arises
39 from the fact that some campaigns request informal opportunities for their candidate to "stop by
40 and introduce themselves" at a delegation or caucus meeting. This often evolves into a spontaneous
41 interview which may not be offered to the other candidates in the same race or may occur when the
42 same delegation has already conducted their interviews for that race. Your speakers believe further
43 clarification is in order. For clarity, any appearance by a candidate before an organized meeting of
44 a caucus or delegation, other than their own, would be considered an interview and fall under the
45 rules for interviews as recommended below.

46
47 Notwithstanding various state laws that allow one party to record an interaction, the Task Force
48 favored full transparency for these interviews and recommended that an interview be recorded only
49 with the full knowledge and agreement of the candidate. No instances in which a candidate
50 declined to be recorded have been reported, but nonetheless, the choice to be recorded should lie

1 with the interviewee / candidate. In those cases where the interview is recorded, it may not be
2 shared outside the group—whether a caucus or a delegation—that conducted the interview.

3
4 *Late announcing candidates*

5
6 Under the newly adopted election rules (G-610.020, ¶4) candidates are officially announced by the
7 Office of House of Delegates Affairs at defined times. Individuals may make an independent
8 announcement of candidacy only after active campaigning is allowed. As previously specified in
9 the referred recommendation, groups conducting interviews with candidates for a given office are
10 required to offer an interview to all individuals that have officially announced their candidacy at
11 the time the group's interview schedule is finalized. Interviewing groups may, but are not required
12 to, interview late announcing candidates. Should an interview be offered to the late candidate, all
13 other announced candidates for the same office (even those previously interviewed) must be
14 afforded the same opportunity. Offering a late announced candidate an opportunity to interview at a
15 different time (perhaps closer to the election) or in a different format (in-person at the meeting
16 itself) could be perceived as an unfair advantage. While our rules continue to allow for late
17 announcements of candidacy, up to and including nomination at the opening session of the House,
18 given the opportunities to announce one's candidacy in advance, late announcements should be
19 extremely rare and should not provide an advantage to such candidates. Thus, the focus of this
20 recommendation is on fairness for all candidates by encouraging transparency and facilitating full
21 vetting of candidates and should be retained.

22
23 TECHNICAL CORRECTION TO POLICY G-610.020

24
25 While dealing with the election rules, your speakers have become aware of the need for a
26 correction to language that was adopted in June. The rules previously required candidates to
27 complete a conflict of interest (COI) disclosure before election, and that part of the policy was
28 reaffirmed. Language in a different recommendation adopted in June would require individuals
29 submitting an announcement of candidacy to include "their conflict of interest statement" along
30 with the announcement. Insofar as the COI disclosure is collected in the year of the election and is
31 not necessary for an announcement, that language should be stricken from paragraph 4 of the
32 policy.

33
34 RECOMMENDATIONS

35
36 This report from your speakers spells out the expectations for interviews, particularly virtual
37 interviews, conducted with those seeking election to leadership positions within our AMA. It is
38 recommended that Policy G-610.020 be amended by addition and deletion to read as follows and
39 the remainder of this report be filed. [Note: Paragraph numbers will be editorially corrected as
40 required.]

- 41
42 (4) Candidates may notify the HOD Office of their intention to run for potential newly opened
43 positions, as well as any scheduled open positions on any council or the Board of Trustees, at
44 any time by submitting an announcement card ~~and their conflict of interest statement~~ to the
45 House Office. They will then be included in all subsequent projections of announcements
46 before the House, "Official Candidate Notifications," and in any campaign activity that had
47 not yet been finalized. All previously announced candidates will continue to be included on
48 each Official Announcement Date. Any candidate may independently announce their
49 candidacy after active campaigning is allowed, but no formal announcement from the HOD
50 office will take place other than at the specified times.

51 ...

- 1 (11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer
2 positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct
3 interviews must designate their interviewing coordinator and provide the individual's contact
4 information to the Office of House of Delegates Affairs. The Speaker's Office will collect
5 contact information for groups wishing to conduct interviews as well as for candidates and
6 their campaign teams and will provide the information as requested.
7
- 8 (12) Interviews conducted with current candidates must comply with the following rules:
9 a. Interviews may be arranged between the parties once active campaigning is allowed.
10 b. Groups conducting interviews with candidates for a given office must offer an interview to
11 all individuals that have officially announced their candidacy at the time the group's
12 interview schedule is finalized.
13 i. A group may meet with a candidate who is a member of their group without
14 interviewing other candidates for the same office.
15 ii. Interviewing groups may, but are not required to, interview late announcing candidates.
16 Should an interview be offered to a late candidate, all other announced candidates for
17 the same office (even those previously interviewed) must be afforded the same
18 opportunity.
19 iii. Any appearance by a candidate before an organized meeting of a caucus or delegation,
20 other than their own, will be considered an interview and fall under the rules for
21 interviews.
22 c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews
23 for an office must be conducted using the same format and platform.
24 d. In-person interviews may be conducted between Friday and Monday of the meeting at
25 which elections will take place.
26 e. Virtual interviews are subject to the following constraints:
27 i. Interviews may be conducted only during a window beginning on the Friday evening
28 two weekends prior to the scheduled Opening Session of the House of Delegates
29 meeting at which elections will take place and must be concluded by the Sunday
30 evening one week before the scheduled Opening Session of the House.
31 ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on
32 weekends between 8 am and 10 pm based on the candidate's local time, unless another
33 mutually acceptable time outside these hours is arranged.
34 iii. Caucuses and delegations scheduling interviews for candidates within the parameters
35 above are not obligated to offer alternatives but are encouraged to do so if possible.
36 f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
37 g. Recordings of interviews may be shared only among members of the group conducting the
38 interview.
39 h. A candidate is free to decline any interview request.
40 i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a
41 contested election, the Vice Speaker, may issue special rules for interviews to address
42 unexpected situations.

Fiscal Note: Less than \$500 to update policy

APPENDIX A – Policy G-610.020, Rules for AMA Elections

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.

(3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker.

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and

not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

(10) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

(14) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

(15) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

(20) Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(24) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

REPORT OF THE SPEAKERS

Speakers' Report 2-N-21

Subject: Establishing an Election Committee

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the June 2021 Special Meeting (J21), the House of Delegates (HOD) adopted the following
2 recommendation as part of the report of the Election Task Force (Speakers' Report 2):
3

4 In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7
5 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum
6 tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly
7 involved in a campaign during their tenure and would be appointed from various regions,
8 specialties, sections, and interest groups. The primary role of the committee would be to work
9 with the Speakers to adjudicate any election complaint. Additional roles to be determined by
10 the Speaker and could include monitoring election reforms, considering future campaign
11 modifications and responding to requests from the Speaker for input on election issues that
12 arise.
13

14 The recommendation is recorded as Paragraph 5 in Policy D-610.998, "Directives from the
15 Election Task Force."
16

17 The Speakers determined that the term of each committee member should run from June to June,
18 starting and ending with the adjournment of the HOD meeting, and initial appointments, including
19 the chair, have been made. The seven members of the Committee are delegates or alternate
20 delegates and have agreed to refrain from active participation in election campaigns through the
21 following June, when their (initial) appointments will have concluded. Current members will be
22 eligible for reappointment and other individuals willing to serve on the Committee are invited to
23 complete the application [form](#) on the Speakers' [page](#) for positions that will begin in mid-2022.
24

25 Members of the Committee are listed in Appendix A. All were selected from among members of
26 the House that submitted an application to serve. Appointments were made to cross the geographic
27 regions and broad specialties represented in our House. The selected individuals have extensive
28 experience with campaigns. Among those selected are past presidents of 4 state medical
29 associations and 2 specialty societies, plus two past state medical association speakers in addition
30 to past members of an AMA Council and Section Governing Councils. As part of their
31 commitment, they have also agreed that all complaints and the ensuing discussions, deliberations,
32 and votes will be kept confidential. Only those complaints that are verified and reported to the
33 House will be shared, and then the Speaker will report to the House only the relevant aspects of the
34 matter. The Committee might be likened to the peer review process. (See below for the complaint
35 process.)

1 In addition, Paragraph 6 of the same policy adopted at J21 reads as follows:

2
3 The Speaker in consultation with the Election Committee will consider a more defined process
4 for complaint reporting, validation, resolution, and potential penalties. This process will be
5 presented to the House for approval.

6
7 This report is in response to Paragraph 6.

8
9 COMMITTEE ACTIVITIES AND PROPOSALS

10
11 The Committee convened by conference call to address the matters that had been assigned. Each is
12 discussed below.

13
14 *Complaint reporting*

15
16 Long established policy (Policy G-610.020 [1]) states that the Speakers “are responsible for overall
17 administration of our AMA elections.” The Committee recommends that complaints continue to be
18 submitted through the Speaker or Vice Speaker. Should either or both have a perceived conflict,
19 complaints may be directed to our AMA’s General Counsel. Counsel will then work with the
20 Committee chair and/or the Speaker or Vice Speaker, depending on the nature and extent of the
21 conflict. AMA’s General Counsel can be reached through the Member Service Center or the HOD
22 Office. Members of the Committee will not accept complaints directly and members of the House
23 should not bring complaints to them or attempt to discuss campaign related concerns with
24 individual members.

25
26 Complaints should generally be based on first-hand information because the necessary information
27 is unlikely to otherwise be available. A complaint will need to include the following details:

- 28
29
 - The name of the person(s) thought to have violated the rules
 - The date of the alleged violation and the location if relevant
 - The specific violation being alleged (i.e., the way the rules were violated)
 - The materials, if any, that violate the rules; original materials are preferred over copies.

32 Where necessary, arrangements for collection of these materials will be made.

33
34
35 Some discussion was had regarding the development of a list of potential rules violations and
36 associated penalties, it quickly was recognized that this list would be limitless, necessarily qualified
37 by nuance or exceptions. Furthermore, application of rigid penalties that do not take into account
38 such nuances, would unnecessarily constrain the committee and potentially disenfranchise
39 members of our House with whom rests the ultimate decision regarding verified infractions.
40 Rather, the Committee recommends that they be allowed flexibility to consider the circumstances
41 surrounding reported violations and to determine the appropriate corrective action. To ensure
42 consistency and fairness over time, a history of the details of each verified offense and the ensuing
43 penalty will be retained by the Office of General Counsel.

44
45 Inquiries about rules should also be directed to the Speakers. They have long interpreted AMA’s
46 election rules, and in fact, the annual election manual further elucidates the campaign rules. In this
47 light some complaints could prove unfounded simply because of a misunderstanding of the rules.
48 More importantly, consistency in explaining the rules is requisite, and the Speakers are familiar
49 with both historical issues and current practice. In addition, questions sometimes arise for which
50 the answer should be widely disseminated, and the Speakers have the ability and tools to share the
51 information. Even-handedness in administering the elections is a hallmark of our processes.

1 *Validation*

2
3 Upon receiving a complaint, the Speaker will consult with the Committee chair to form a
4 subcommittee of three members to investigate the allegation. The subcommittee members will be
5 selected to avoid conflicts (e.g., being part of the same delegation as the alleged violator). Using
6 necessary discretion, the subcommittee shall investigate the complaint and will report to the full
7 Committee whether the complaint is founded. When necessary, the Office of General Counsel or
8 the HOD Office will assist.

9
10 Following the subcommittee's evaluation, the full Committee will meet as soon as practical but
11 generally within 2 weeks, to hear the subcommittee's report, determine whether a violation has
12 occurred, and establish appropriate next steps. Committee members with a conflict of interest will
13 be expected to recuse themselves from the vote, although they may participate in any discussion
14 that precedes the decision. These internal deliberations are confidential, and details will not be
15 shared. The Speakers are ex officio members of the Committee, without vote except as necessary to
16 break a tie within the Committee, when one of them may vote.

17
18 *Resolution and potential penalties*

19
20 Historically, the only formal penalty for a campaign violation was for the Speaker to announce to
21 the House before the election that a violation had occurred by naming the violator and the
22 violation. These announcements thankfully have been rare, but when such an announcement has
23 been made, it is noted that the candidate subsequently lost the election.

24
25 The Committee believes the House should continue to be the final arbiter when violations are
26 deemed to be significant; thus, the Speaker announcing a violation to the House will remain a
27 penalty which the Committee may impose. At the same time the Committee may believe that this
28 penalty is excessive for some violations. The Committee should consider mitigating circumstances
29 such as inadvertent breaches and technical or typographical errors. The Committee should also
30 consider when during the year the violation occurs, the likely advantage sought or gained by the
31 action in question, and who committed the violation. Consequently, the Committee recommends
32 that it be given discretion to determine appropriate resolution of a validated complaint. In many
33 circumstances resolution may be accomplished by corrective action, short of announcement to the
34 House.

35
36 No exhaustive list of situations is possible, but three principles would seem to capture relevant
37 aspects of violations:

- 38
39 • The more remote in time the violation occurs, the less the need to declare a violation, and
40 conversely, the nearer the election, the greater the need for an announcement by the
41 Speaker.

42
43 It seems likely that a violation, particularly a violation that is perceived to be serious, will
44 become generally known if it occurs well before the election. At the same time, awareness
45 of a violation on the eve of the election has little chance of propagating and may warrant an
46 announcement.

- 47
48 • The greater the advantage sought or gained, the more the need for a public announcement.

49
50 Some subjectivity is apparent in this principle, but the Committee believes that both the
51 motivation and the benefit of the violating activity need to be addressed. An inadvertent

violation that greatly advantages a candidate is more serious than the same inadvertent violation that for some reason handicaps the candidate.

- The greater the culpability of the candidate, the greater the need for an announcement to the House.

Under AMA's election rules, the candidate is responsible for all campaign activities, including those carried out by the candidate's supporters. While it would be unwise to simply ignore a violation committed by a naïve supporter (or group), the role of the candidate her- or himself certainly needs to be considered. In the same way "plausible deniability" alone will not absolve the candidate, though it may decrease the likelihood of Speaker pronouncements.

As noted above, announcing the Committee's conclusion to the House that a violation has occurred should remain an option, but the Committee also favors availability of other options whereby relatively minor infractions may be easily and quickly remedied without being reported to the House. This may also be appropriate in those cases where the violation and corrective action is readily apparent without formal announcement. For example, Paragraph 15 of the rules (Policy G-610.020) requires candidates using electronic communications to "include a simple mechanism to allow recipients to opt out of receiving future [emails]." A candidate failing to provide the "simple mechanism" could easily correct the violation by sending another communication apologizing and adding the opt out, which would be apparent to all recipients, meaning that reporting the violation to the House would be of little need. For another example, a misstatement in an interview or on campaign materials could be subsequently corrected by the candidate by notification to those that received the misinformation.

Where a confirmed violation is deemed by the Election Committee to require a report to the House, the Speaker would report pertinent details, including any corrective action undertaken by the candidate, that are deemed appropriate for the HOD to consider. A notice to the House, separate from a meeting, could be provided when appropriate. For example, such notice could be included with the Speakers' planned announcements of candidates (see Policy G-610.020 [3]), which would allow the House to assess the gravity of the violation but also provide the violator with the opportunity to respond to concerns. Violations that occur once the Annual Meeting has convened, if determined by the Committee to be significant, would be announced during a session of the HOD.

CONCLUSION

The final recommendation of Speakers' Report 2 (Report of the Election Task Force) adopted at the J21 Special Meeting (Policy D-610.998) provides for a review of the reforms related to our election processes. The Election Committee itself and these recommendations will be subject to this review. Our tradition of professionalism and collegiality should result in few violations of our campaign principles and rules necessitating invoking the process detailed here. The Election Committee has recommended a process that draws upon our traditions, provides appropriate flexibility without undue complexity, and yet maintains the integrity of our elections. Accordingly, your Election Committee asks that the following recommendations be approved for use in the upcoming open campaign season and that the Committee be allowed to continue to monitor our election processes with further recommendations in the future as needed.

1 RECOMMENDATIONS

2
3 It is recommended that the following recommendations be adopted and the remainder of the report
4 be filed.

- 5
6 1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as
7 follows:

8
9 Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the
10 AMA General Counsel and should include the following details:

- 11
12 • The name of the person(s) thought to have violated the rules
13 • The date of the alleged violation and the location if relevant
14 • The specific violation being alleged (i.e., the way the rules were violated)
15 • The materials, if any, that violate the rules; original materials are preferred over copies.
16 Where necessary, arrangements for collection of these materials will be made.

17
18 Campaign violation complaints will be investigated by the Election Committee, which will
19 determine penalties for validated complaints as appropriate. Penalties may include an
20 announcement of the violation by the Speaker to the House. (New HOD Policy)

- 21
22 2. The Election Committee will review the Campaign Complaint Reporting, Validation, and
23 Resolution Process as implemented and make further recommendations to the House as
24 necessary. (Directive to Take Action)

- 25
26 3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than \$500 to update policy. Costs for the Committee's operation, minimal.

Appendix A – Members of the Election Committee

The following delegates and alternate delegates were selected for the initial election committee from among those who submitted applications. All have agreed to not be a candidate or to be directly involved in a campaign and will not seek reappointment for any year in which the individual intends to be a candidate or directly involved in a campaign:

- Lynda Young, MD, Chair, Delegate, Massachusetts Medical Society (pediatrics)
- Michael DellaVecchia, MD, PhD, Delegate, Pennsylvania Medical Society (ophthalmology)
- John Flores, MD, Delegate, Texas Medical Association (internal medicine)
- George Hruza, MD, Alternate Delegate, Missouri State Medical Association (dermatology)
- Josh Lesko, MD, Sectional Resident and Fellow Delegate (Medical Society of Virginia; emergency medicine)
- Ted Mazer, MD, Delegate, California Medical Association (otolaryngology)
- Nancy Mueller, MD, Delegate, Medical Society of New Jersey (neurology)

The Speakers serve ex officio, without vote, except to break ties.

Appendix B - Policies Relevant to this Report

D-610.998, Directives from the Election Task Force

Campaign Receptions

1. Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception.

Campaign literature

2. An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

Interviews

3. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

Voting Process and Election Session

4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

Election Committee

5. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise.

6. The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval.

Review of Implementation

7. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.

Policy G-610.020, Rules for AMA Elections

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.

(3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker.

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (i.e., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior

election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next Annual Meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

(10) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.

(13) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.

(14) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

(15) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.

(16) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.

(17) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

(18) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(19) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

(20) Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

(21) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, OR (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(22) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(23) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(24) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(N-21)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and
Detention Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people
2 who have been accused and/or convicted of a crime¹; and
3

4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,
5 people awaiting trial or sentence, or young offenders for short periods of time²; and
6

7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual
8 confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary
9 violations in correctional facilities and detention centers³; and
10

11 Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as
12 not standing up for headcount or not returning a food tray^{3,4}; and
13

14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means
15 of reprisal for reporting unsafe and unsanitary conditions^{5,6}; and
16

17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of
19 infectious disease⁷; and
20

21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary
23 measure overseen by medical professionals who treat prisoners with compassion and provide
24 prisoners resources to aid their recovery⁷; and
25

26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around
27 60,000 people, currently reside in some form of solitary confinement⁸; and
28

29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average
30 of \$75,000 per prisoner per year⁹; and
31

32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are
33 offered few or no educational, vocational, or rehabilitative programs¹⁰; and
34

35 Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated
36 with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic
37 stress disorder, and psychosomatic behavior changes¹¹⁻¹³; and

1 Whereas, There is a strong association between solitary confinement and self-harm, for
2 instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher
3 suicide rate within the first year after release and another study analyzing over 240,000
4 incarcerations found that prisoners who experienced solitary confinement accounted for over
5 50% of self-harm incidents despite accounting for only 7.3% of prison admissions^{4,13,14}; and
6

7 Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an
8 opioid overdose in the first two weeks after release and 24% more likely to die from any cause
9 in the first year after release, even after controlling for potential confounding factors, including
10 substance use and mental health disorders¹⁴; and
11

12 Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a
13 higher overall 5-year mortality those who do not¹⁵; and
14

15 Whereas, A United States Department of Justice study indicates that inmates with mental
16 illnesses are more likely to be put in solitary confinement and that solitary confinement further
17 exacerbates their mental illnesses¹⁶; and
18

19 Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term
20 neurobiological consequences, increasing mentally ill prisoners' need for psychiatric
21 services^{12,13}; and
22

23 Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of
24 homelessness and unemployment after release, in part due to the lasting psychological stress
25 of confinement¹⁷; and
26

27 Whereas, Spending any amount of time in solitary confinement is associated with two times the
28 risk of being reincarcerated within two weeks of release and other studies found a 10-25%
29 increased overall risk of recidivism^{14,18-20}; and
30

31 Whereas, Parolees released from solitary confinement commit new crimes in their community
32 35% more than parolees released from the general prison population, threatening community
33 safety¹⁹; and
34

35 Whereas, Transitioning prisoners from solitary confinement to the general prison population
36 prior to release reduces recidivism rates²⁰; and
37

38 Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions,
39 certain racial minorities are disproportionately more likely to be placed in solitary confinement
40 while white prisoners are 14% less likely to be placed in solitary confinement⁸; and
41

42 Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will
43 be placed in solitary confinement are 80% greater than heterosexual men and the odds are
44 190% greater that lesbian and bisexual women will be placed in solitary confinement than
45 heterosexual women²¹; and
46

47 Whereas, The United Nations and The International Convention on the Rights of the Child
48 prohibit the solitary confinement of anyone under the age of 18^{22,23}; and

1 Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum
2 Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the
3 use of solitary confinement for prisoners with mental or physical disabilities when their
4 conditions would be exacerbated by such measures²³; and

5
6 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than
7 15 days, because it is “cruel, inhuman or degrading treatment or punishment”²³; and

8
9 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in
10 exceptional cases as a last resort, for as short a time as possible and subject to independent
11 review”²³; and

12
13 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical
14 and psychological health issues, and should be considered cruel and unusual punishment and a
15 human rights violation²⁴; and

16
17 Whereas, At least some United States correctional facilities have managed to reform and
18 reduce their use of solitary confinement in order to better respect the dignity and human rights
19 of inmates while still maintaining the safety of correctional officers and inmates in jails and
20 prisons¹⁸; and

21
22 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%
23 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff
24 violence¹⁸; and

25
26 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement
27 population, violent incidents also dropped by nearly 70%¹⁹; and

28
29 Whereas, A 2015 study found that placing male inmates who were violent in solitary
30 confinement did not effectively deter or alter the probability, timing, or development of future
31 misconduct or violence²⁵; and

32
33 Whereas, Some correctional facilities have created special units to protect vulnerable groups
34 together with similar access to privileges and programs available to the general population
35 without using solitary confinement as a means of protection¹⁸; and

36
37 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for
38 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New
39 York City²⁶; and

40
41 Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for
42 disciplinary purposes in correctional facilities; therefore be it

1 RESOLVED, That American Medical Association Policy H-430.983, "Reducing the Use of
2 Restrictive Housing in Prisoners with Mental Illness," be amended by addition and deletion to
3 read as follows:

4
5 ~~Reducing~~ Opposing the Use of Restrictive Housing in for Prisoners ~~with Mental Illness~~
6 H-430.983

7 Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length,
8 ~~with rare exceptions,~~ for incarcerated persons ~~with mental illness,~~ in adult correctional
9 facilities and detention centers, except for medical isolation or to protect individuals
10 who are actively being harmed or will be immediately harmed by a physically violent
11 individual, in which cases confinement may be used for as short a time as possible;
12 and (2) while solitary confinement practices are still in place, support efforts to ensure
13 that the mental and physical health of all individuals placed in solitary confinement are
14 regularly monitored by health professionals; and (3) encourage appropriate
15 stakeholders to develop and implement safe, humane, and ethical alternatives to
16 solitary confinement for incarcerated persons in all correctional facilities.; ~~and (3)~~
17 ~~encourage appropriate stakeholders to develop and implement alternatives to solitary~~
18 ~~confinement for incarcerated persons in all correctional facilities.~~ (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has increasingly recognized the priority and urgency of addressing health injustices. The mental health detriments of solitary confinement are well-documented and openly opposed by international groups as a form of cruel and unusual punishment. As this resolution demonstrates, humane alternatives are available to ensure safety and prevent violence. Using solitary confinement is actively harmful to the future of these individuals once they are released and has a detrimental effect on later attempts to reduce recidivism rates. Our delegation has worked to solicit review from advocacy and staff to ensure the issue is timely, addresses a gap in policy, and without substantial concerns on feasibility or actionability, and therefore would ask the House to take timely action on behalf of an incredibly vulnerable population.

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Res. 412, A-18.

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and

(3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Res. 001, A-18.

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17.

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

BOT Rep. 24, A-18.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(N-21)

Introduced by: Medical Student Section

Subject: Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The American Association of Physical Anthropologists believes that “race does not
2 have its roots in biological reality, but... has become a social reality that structures societies
3 and how we experience the world. In this regard, race is real, as is racism, and both have real
4 biological consequences”;¹ and
5

6 Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as
7 belonging to a unique, independent racial category in the U.S. Census data, and instead they
8 are aggregated under “White”;² and
9

10 Whereas, MENA designation is not included in the National Institute of Health’s racial
11 categories, and thus is not required to be considered in any federally-funded research;³ and
12

13 Whereas, MENA is not included as a race category routinely collected in survey and
14 demographic data in the U.S.;^{4,5} and
15

16 Whereas, There are discrepancies in estimates of the total MENA population across the US due
17 to lack of a racial identifier;^{2,5} and
18

19 Whereas, There lack of a racial identifier for MENA populations has limited research on this
20 population in the US to ethnic enclaves, which may not be reflective of the community as a
21 whole;^{4,6} and
22

23 Whereas, Americans of MENA descent disproportionately constitute recent immigrants to the
24 U.S., share a set of cultural norms, and face marginalization and discrimination;^{4,5,6,7,8,9} and
25

26 Whereas, To the knowledge of the authors there has never been a prospective study examining
27 the health needs of MENA communities in the U.S.;⁴ and
28

29 Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some
30 MENA populations due to higher rates of consanguineous marriages, most commonly with first
31 cousins;¹⁰ and
32

33 Whereas, Discrimination against MENA populations in the U.S. increased dramatically after
34 September 11th, 2001, including increased harassment, violence, and targeted hate crimes that
35 have resulted in worsening health outcomes in this population;^{6,11,12} and

1 Whereas, Classifying MENA populations as “White” has led to their “cultural invisibility” and
2 perpetuates a cycle of undocumented health disparities that affects funding for health-related
3 research, targeting of effective and personalized healthcare, and prevents patient-centered care
4 and engagement;^{4,5,6,10,13} and

5
6 Whereas, Including a race identifier for MENA populations on all medical records will increase
7 the representation and visibility of the population, and increase the research and attention to the
8 medical and public health needs of this community;^{4,5,6,14} and

9
10 Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that “it is optimal to use a
11 dedicated ‘Middle Eastern or North African’ response category,” the Census Bureau declined to
12 include a MENA identifier in the 2020 Census;¹⁵ and

13
14 Whereas, Our AMA had supported the addition of MENA as a “distinct reporting category” in a
15 2016 letter to the Chief Statistician at the Office of Management and Budget, but has not
16 publicly engaged on this issue since then and does not list “MENA” as a race option on AMA
17 demographics forms;¹⁶ and

18
19 Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it
20 vitally important in the promotion of medicine and public health, and the Census has
21 acknowledged that its inaccuracies in collection of race data act as a barrier to its utility and
22 accuracy;¹⁷ and

23
24 Whereas, Our AMA “recognizes that race is a social construct and is distinct from ethnicity,
25 genetic ancestry, or biology” (H-65.953); and

26
27 Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of
28 data in order to appropriately target research, preventive measures, and healthcare
29 engagement; therefore be it

30
31 RESOLVED, That our American Medical Association add “Middle Eastern/North African
32 (MENA)” as a separate race category on all AMA demographics forms (Directive to Take
33 Action); and be it further

34
35 RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle
36 Eastern/North African (MENA)” as a separate race category on all surveys conducted by the
37 U.S. Census Bureau, and for all federally funded research using race categories (Directive to
38 Take Action); and be it further

39
40 RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle
41 Eastern/North African (MENA)” as a separate race category on all medical school and residency
42 demographics forms. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Since the fall of Afghanistan to the Taliban, more than 100,000 Afghan refugees are expected to arrive in the US. Over 4 million people in America of Middle Eastern and North African (MENA) descent are currently identified as “White” by the US Census Bureau, creating an invisible minority. This leaves MENA populations to choose between misidentifying their race or being forced to check off “Other”, as many have done on AMA forms and at every level of the medical system. As our AMA and society at large moves to rectify the systemic racism and marginalization facing many communities, it is time for us to speak out for thousands of our MENA colleagues and millions of patients.

It is imperative that we act on this today, so we can create a more inclusive environment for every MENA individual in this nation. Any delay in consideration means another year with millions of patients marginalized, health disparities missed, and AMA members feeling excluded. Every year we wait is \$675 billion in misallocated federal and state funds, all distributed based on the annual American Community Survey conducted by the Census Bureau.

This is a resolution that fills a clear gap in AMA and federal policy. In 2017, the Census Bureau agreed to include “MENA” as a separate race on the 2020 Census, only to backtrack in 2018 and has not commented on the issue since then. If adopted, this policy could help alleviate a glaring disparity in medical training, medical practice, and research.

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RELEVANT AMA POLICY

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Res. 001, I-17, Appended: Res. 403, A-19

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

Res. 03, I-19

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates

how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities. 4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. Res. 11, I-20

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes anti-racist strategies to mitigate algorithmic bias in medicine.

Res. 10, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

CMS Rep. 7, I-20

Protecting the Integrity of Public Health Data Collection H-440.817

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

Res. 002, I-18

Maintaining Validity and Comprehensiveness of U.S. Census Data H-350.952

Our AMA will support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated.

Res. 221, A-18

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;

(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;

(3) physicians recognize that race and ethnicity are conceptually distinct;

(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;

(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;

(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and

(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

CSA Rep. 11, A-98 Appended: Res. 509, A-01 Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Report 01, A-21

Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996

Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient.

Res. 4, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CSA Rep. 8, A-05 Modified: CSAPH Rep. 1, A-15 Modified: Res. 03, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(N-21)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community, including disproportionate rates of incarceration,⁵⁻⁷ residential segregation,⁸ and unfair labor and employment policies;¹⁻⁴ and

Whereas, Toxic stresses of racism, incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior¹⁰, disease, and early death in minority children^{9, 11,12}; and

Whereas, The racial wealth gap in the United States has increased dramatically, as households with Black children hold just one cent for every dollar held by households with non-Hispanic White children as of 2016^{13,14}; and

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes^{15,16}; and

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities, which are correlated with positive health outcomes, for the African American community^{17,18,19,20}; and

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations^{14,21}; and

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities²¹; and

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including \$5.5 million in direct compensation, free college education to survivors, a formal apology from the city, and education on police torture in public schools²²; and

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities; and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989^{14,21,23}; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes^{23–25}; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over \$60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past^{26,27}; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation^{28–30}; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population^{14,30,31}; and

Whereas, The Black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly Black medical schools after the 1910 publication of the Flexner Report³¹; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships^{32,33}; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders³³; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$110,000.

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution is timely with pending legislative discussions in Congress. Over the past years, our AMA has begun a movement attempting to redress our decades-long contributions to medical racism. This resolution is urgent, as it asks our AMA to support a Congressional commission to make recommendations on reparations, for which federal legislation has already been introduced (HR 40, the Commission to Study and Develop Reparation Proposals for African Americans Act), making now an ideal time for the AMA to act. This resolution also asks the AMA to study mechanisms of economic and healthcare reparations, a necessary, vital next step if the AMA truly intends to advance racial justice in medicine. This resolution gives our AMA the opportunity to lend a powerful voice, at an extremely timely and important juncture, towards true health equity through the study of the feasibility of reparations and their potential to contribute to undoing the deep health disparities that hold our nation back.

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health

issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

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

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

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

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

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

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

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(N-21)

Introduced by: Medical Student Section

Subject: Guidelines on Chaperones for Sensitive Exams

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

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

7 Whereas, The presence of medical chaperones is a common practice during sensitive exams
8 for patients^{3,4}; and
9

10 Whereas, Physicians can be reported for alleged misconduct that never occurred, but is difficult
11 to disprove without witnesses⁵; and
12

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

18 Whereas, A study investigating whether medical chaperones affect patient satisfaction had
19 results indicating that 61% of adolescent patients preferred to be offered a chaperone^{3,4}; and
20

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

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

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

33 Whereas, Some institutions require formally trained chaperones, including 7 states
34 implementing legal mandates for the presence of medical chaperones during sensitive physical
35 exams⁹⁻¹³; and

1 Whereas, Requiring a chaperone for every single sensitive exam may place a greater burden on
2 staff and increase health care costs, and thus should not be institutionally mandated for every
3 exam; and
4

5 Whereas, Patients may not want an extra person present for sensitive examinations due to the
6 private nature of such examinations, and thus an opt-in/opt-out policy is more preferable to a
7 fully mandated policy¹⁴; and
8

9 Whereas, Documentation of patient interaction has been shown to decrease rates of litigation
10 ruled against providers¹⁵; and
11

12 Whereas, Patients may be uncomfortable requesting a chaperone when the provider asks
13 themselves due to intimidation or fear of undermining the trust in the patient-provider
14 relationship, and a study found that 54% of patients preferred to have the nurse ask about
15 chaperone preference rather than the physician ⁵; and
16

17 Whereas, Chaperones may feel uncertain or concerned about intervening during an
18 inappropriate exam or reporting potential misconduct, especially if they are hierarchically inferior
19 to the provider, calling for a need for educating chaperones on proper conduct¹³; and
20

21 Whereas, AMA policy states any authorized member of the health care team can serve as a
22 medical chaperone as long as there are clear expectations to uphold professional standards of
23 privacy and confidentiality, failing to address potential discomfort a chaperone may have in
24 reporting egregious behavior during exams; and
25

26 Whereas, There have been instances of litigation when patient declined a chaperone during an
27 exam¹⁶; and
28

29 Whereas, Physicians may feel uncomfortable performing sensitive exams on patients without a
30 chaperone due to fear of litigation or discomfort with patient conduct during an exam; and
31

32 Whereas, American Association of Family Physicians Policy suggests that providers should not
33 allow the process of ensuring that an exam is chaperoned to interfere with appropriate and
34 timely patient care and clinical judgment; and
35

36 Whereas, AMA and ACOG policy have extensive protection guidelines for patients, but do not
37 include guidelines to protect physicians¹⁷; therefore be it
38

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

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Sensitive physical examinations provoke anxiety in patients and providers alike. With increasing concerns in recent years over sexual harassment and misconduct, more attention has been paid to the importance of chaperones for sensitive exams and for correct provider use and understanding of these chaperones. Given this increased attention and recent high-publicity problematic actions (for example, Larry Nassar's horrific treatment of generations of U.S. gymnasts), we believe our AMA Council on Ethical and Judicial Affairs should revisit the sections pertaining to these topics in the AMA's Code of Ethics. We believe this is a timely, important, and relevant ask.

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RELEVANT AMA POLICY

1.2.4 Use of Chaperones

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

Physicians should:

(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.

- (b) Always honor a patient's request to have a chaperone.
 - (c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
 - (d) In general, use a chaperone even when a patient's trusted companion is present.
 - (e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.
- Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(N-21)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine
and Medical Professionalism

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as
2 well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or
3 the right to keep hair in an uncut or untrimmed manner ¹; and
4

5 Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for
6 cultural purposes and serves as a way to express values of a demographic group or particular
7 society for religious, spiritual, or gender identification ²; and
8

9 Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for
10 racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural
11 headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious
12 association ³⁻⁶; and
13

14 Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate
15 against any individual based on an "... individual's race, color, religion, sex, or national origin,"
16 and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also
17 unintentional discrimination on the enumerated proscribed ground ⁷; and
18

19 Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part
20 of medical professionalism standards tend to be euro-centric and penalize those with non-euro-
21 centric phenotypical features and/or culture ^{8,9}; and
22

23 Whereas, In 2019, the State of California and New York City passed laws to address hair
24 discrimination within the workplace through the CROWN Act (SB 188) and the NYC
25 Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the
26 Basis of Hair ^{1,3}; and
27

28 Whereas, United States Armed Forces have repealed several bans on natural hair and cultural
29 headwear in the workplace (Army Regulation 670-1, Section 3-2) ¹⁰; and
30

31 Whereas, Qualitative analysis of minority resident physicians has revealed the additional
32 challenges to embracing their racial identities in a professional setting results in less job
33 satisfaction and more susceptibility to burnout ¹¹; and
34

35 Whereas, Studies show "a positive association between physician-patient racial/ethnic
36 concordance and patients' receiving preventive care, being satisfied with their care overall..." ¹²;
37 and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Current AMA and federal policies do not recognize guidelines that discriminate against natural hairstyles and cultural headwear as workplace discrimination. However, targeted hairstyles and/or headwear are known proxies for racial, ethnic, religious, and/or sexual minority groups and thereby should be protected by Title VII of The Civil Rights Act. This issue is especially relevant for students, residents, and young physicians, who feel pressure to spend their already scarce time and money to change their appearance to fit the mold of Eurocentric “professional” appearances. This issue has been and continues to be urgent because it is causing hardship and increasing burnout in students and physicians from marginalized groups, who already bear a disproportionately high burden of stress and increased burnout.

To date, 12 states and the American Academy of Pediatrics have passed laws and policies related to *Creat(ing) A Respectful and Open World for Natural Hair (CROWN)*. Within medical schools, residencies, and hospital settings, professionalism guidelines are euro-centric and penalize non-euro-centric phenotypic features being displayed in the healthcare setting, leading to decreased job satisfaction and increased burnout for already marginalized and underrepresented groups. Our AMA has a long and shameful history of participating in and perpetuating racial discrimination; this resolution gives our organization the opportunity to be a leader in setting standards that will make healthcare more welcoming and open to all.

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

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.

BOT Rep. 27, A-19

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public

health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14, Reaffirmed in lieu of: Res. 001, I-16, Reaffirmation: A-17

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98, Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07, Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

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

Our AMA:

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

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

Eliminating Religious Discrimination from Residency Programs H-310.923

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances.

CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

BOT Action in response to referred for decision: Res. 602, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(N-21)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Race is a self-identified social construct that results in differential treatment of groups
2 that leads to social inequity on people's health^{1,2}; and
3

4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-
5 identification of their origin or descent, "roots," heritage, or place where the individual or their
6 parents or ancestors were born³; and
7

8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);
9 and
10

11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and
13 Chicano/a/x" have been used interchangeably with race in case report⁴⁻⁷; and
14

15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of
16 origin and cultural heritage, constructs which can change over time^{8,9}; and
17

18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based
19 consensus is necessary for optimal use of self-identified race as well as geographical
20 ancestry¹⁰; and
21

22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine¹¹;
24 and
25

26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency
29 department¹²; and
30

31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in
32 2015, there was substantial variation between states in administrative data misclassification of
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native
34 beneficiaries¹³; and
35

36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the
37 62 studies provided complete descriptions of their study populations¹⁴; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity¹⁵; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results¹⁶; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients¹⁶; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology¹⁶⁻¹⁸; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women⁴; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women¹⁹; and

Whereas, It was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences⁴; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care²⁰; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, Our AMA “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias²¹; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; (New HOD Policy) and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The current momentum toward addressing racial and ethnic discrimination and inequities has been particularly important in medicine and medical research. These fields have a long and shameful history of racism, which is especially evident in the ways in which race and ethnicity are improperly used in scientific journal articles. Our AMA witnessed this firsthand during a recent incident with a JAMA podcast. The episode's misunderstanding of race and racism were extremely harmful and revealed how far medicine and science still have to go to undo the medical racism that has been taught and learned in these systems. Our AMA has already established policy discerning that race and ethnicity are distinct social categories. It is in the jurisdiction of our AMA to support scientific data that correctly aligns with the related but distinct nature of these words. The resolved clauses of this resolution are supported by H-350.974, specifically "Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Our AMA supports the use of evidence-based guidelines to promote the consistency and equity in care and has further recognized the importance of health justice toward providing the best care for all. This resolution provides a timely and important next step in ensuring that the research that guides our medical practice is accurate and usable to healthcare generations to come.

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RELEVANT AMA POLICY:

Code of Medical Ethics 7.1.5

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
 - (b) Resolve charges expeditiously.
 - (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
 - (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
 - (e) Maintain accurate and thorough documentation throughout the process.
 - (f) Maintain the highest degree of confidentiality.
 - (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.
- Issued: 2016

Code of Medical Ethics Opinion 8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health

literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Racial and Ethnic Disparities in Health Care, H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

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

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

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

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

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

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

Reducing Discrimination in the Practice of Medicine and Health Care Education, D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

BOT Action in response to referred for decision: Res. 602, I-15

Improving the Health of Black and Minority Populations, H-350.972

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Reducing Racial and Ethnic Disparities in Health Care, D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities, D-350.996

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(N-21)

Introduced by: Medical Student Section

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Reports

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Patients of color often have worse healthcare outcomes than White patients,
2 particularly noticeable in the decreased life expectancies for Black and Indigenous patients^{1,2};
3 and
4

5 Whereas, Non-Hispanic White patients report lower satisfaction with their doctors, and patients
6 of color routinely report worse treatment and experiencing bias and racism when accessing
7 care^{1,3}; and
8

9 Whereas, Medical racism has been present throughout history and its legacy continues to
10 unfold today, manifesting as unethical experiments and substandard, unnecessary, or incorrect
11 treatments being given to minoritized racial groups historically and continuing to be discovered
12 even today^{4,5}; and
13

14 Whereas, The perpetuation of racial bias begins early in preclinical medical education, such as
15 when race is taught to be a biological factor or a substitute for education, income, or genetics,
16 which also deeply harms medical trainees from minoritized communities by perpetuating the
17 belief that their race makes them biologically different, unusual, or inferior^{6,7}; and
18

19 Whereas, A common example is that Black race is often used as a proxy for sickle cell trait or
20 disease, ignoring that sickle cell genetics can and do occur in people of any race, leading to
21 missed diagnoses in some individuals and also opening the possibility of “premature closure” in
22 diagnoses of Black patients experiencing symptoms that are similar to sickle cell but are
23 occurring due to a different pathological process^{7,8}; and
24

25 Whereas, Analyses of lecture slides and clinical vignettes used in medical education have found
26 that race or ethnicity is often presented as a biological risk factor or linked to certain behaviors,
27 without addressing social context or history⁹⁻¹¹; and
28

29 Whereas, During training, medical students learn to use race as a heuristic in preclinical exams
30 and on standardized licensing examinations, with a study of first- and second-year medical
31 students finding that all participants believed that if race was used in a board-style question, it
32 was likely relevant to answering the question correctly¹²⁻¹⁴; and
33

34 Whereas, A 2017 study of common USMLE Step 1 preparation material found that of 2,011
35 questions, 455 (20.6%) referred to race or ethnicity in the question stem, answer, or educational
36 objective, with 412 cases (90.5%) only mentioning it as a descriptor without a stated educational
37 objective, while the other 43 cases (9.45%) made race or ethnicity central to the case¹⁵; and

Whereas, It has been argued, including in the *AMA Journal of Ethics*, that race should (a) be obtained as directly identified by the patient themselves and (b) be recorded in the social history, rather than the first line in a case presentation, to help decrease the possibility of race being inappropriately used as a proxy while still recording this social factor as identified by the patient so that important social impacts like the patient's experiences with discrimination and racism can still be understood^{10,16-18}; and

Whereas, The AMA has committed to recognizing and addressing the harmful effects of racism in medicine, medical training, and medical research (H-65.952, H-65.953, D-350.984, H-165.822, D-350.981); therefore be it

RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further

RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has finally begun to take earnest action to actively address the long and shameful history of racism in medicine. The reach of racism in medicine is broad and deep, and many long-accepted medical practices have been found to perpetuate racism and subsequently changed. One practice in need of changing is that of including a patient's race in the initial description of that patient. Race has been included at the beginning of case reports, case presentations, clinical vignettes, lecture slides, standardized test questions, morbidity, and mortality reports, and more. This practice teaches students and reinforces for physicians the use of race as a biological factor or a heuristic for social, cultural, or behavioral traits. Besides being discriminatory and stereotypical, this practice has been shown to be inaccurate, to result in worse outcomes for patients, and to cause psychological harm to physicians and students of minoritized races.

Our AMA has made a commitment to changing the course of medical racism and medical discrimination. It is vital that we continue to address and eliminate the way racism permeates medical practices. This resolution offers a concrete, tangible, and necessary next step in this process.

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RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological

model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Res. 11, I-20

Reducing Discrimination in the Practice of Medicine and Healthcare Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

BOT action in response to referred for decision, Res. 602, I-15

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

CME Rep. 7, I-20

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Res. 10, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(N-21)

Introduced by: Medical Student Section

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers,
H-420.954

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC)
2 or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to
3 dissuade women from seeking legal abortion to terminate pregnancy¹; and
4

5 Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive
6 medical facilities with licensed clinical professionals despite offering only select services,
7 providing misinformation regarding abortion and contraception, and being largely staffed by
8 volunteers instead of licensed care providers^{2,3}; and
9

10 Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable
11 populations like minority and low-income women, which are the target population pursued by
12 Pregnancy Counseling Centers⁴; and
13

14 Whereas, Our AMA submitted an amicus brief to the U.S. Supreme Court in the case titled
15 *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, in support of
16 California's 2016 Reproductive Freedom, Accountability, Comprehensive Care and
17 Transparency (FACT) Act on the basis of "medical ethics and a patient's right to informed
18 consent"; and
19

20 Whereas, California's FACT Act would have required all licensed medical facilities to publicly
21 post information about affordable abortion and contraception services offered on their premises
22 and required all unlicensed CPCs to disclose that they were not licensed medical clinics⁵⁻⁷; and
23

24 Whereas, The public health repercussions that these entities pose by influencing women's
25 reproductive health decisions is well established by putting women at greater risk when they are
26 interrupted from seeking abortions in a timely manner, therefore subjecting them to the
27 increased risk associated with late term abortions or unsafe abortions⁸; and
28

29 Whereas, Pregnancy Counseling Centers perpetuate decreased prenatal care, substance
30 abuse, preterm births, and increased incidence of negative physical and mental outcomes of
31 babies that are born to women with unintended pregnancies⁸; and
32

33 Whereas, Our AMA recognizes the unethical practices utilized by Pregnancy Counseling
34 Centers, such as providing misleading and false information that falls outside of medical
35 standards, in the *Journal of Medical Ethics*⁹; and
36

37 Whereas, These practices can cause women to miss abortion law cutoffs, receive dangerous
38 late-stage abortions, and obstruct general access to abortion, all of which violate the ethical
39 standards of beneficence, respect for autonomy, nonmaleficence, and justice⁹; and

1 Whereas, Pregnancy Counseling Centers often use federal funds from programs like Temporary
2 Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title
3 X family planning funding programs to fund their clinic's services despite only offering a limited,
4 and often incomplete, number of services^{10, 11}; and
5

6 Whereas, Pregnancy Counseling Centers can be funded by anti-choice organizations despite
7 not disclosing this connection, such as profits made by "Choose Life" license plates which fund
8 Pregnancy Counseling Centers in 32 states¹²; and
9

10 Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as
11 of 2015, \$60 million in federal abstinence and marriage promotion funds have gone to
12 Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling
13 Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to
14 Pregnancy Counseling Centers^{13, 14}; and
15

16 Whereas, A survey of 254 websites that identify individual Pregnancy Counseling Centers
17 revealed only 85 contained information on male condoms or sexually transmitted infections
18 (STIs), and of these 85, 63.5% discouraged condom use by providing negative facts about
19 condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or
20 videos of youth on their homepage to target younger populations¹⁵; and
21

22 Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on
23 search engine results, billboards, and buses near abortion clinics with abortion-related terms
24 while hiding their agenda to dissuade women from seeking legal abortions¹⁶; and
25

26 Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful
27 tactics to dissuade women from seeking legal abortion such as wearing white coats although
28 they hold no medical training, failing to disclose they are not a medical facility, expressing
29 judgement to clients about their decisions to pursue abortion or contraception, offering
30 ultrasound services for purpose of using fetal images to dissuade women from abortion, and
31 providing false information on the links between abortion and adverse mental health sequelae,
32 breast cancer, and future infertility^{16, 17}; and
33

34 Whereas, Pregnancy Counseling Centers do not charge for services and are often not licensed
35 medical practices, therefore they are not held to the same state consumer protection statutes
36 and consumer protection regulations that medical practices must abide by⁹; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-420.954, "Truth and
2 Transparency in Pregnancy Counseling Centers," by addition and deletion to read as follows, to
3 further strengthen our AMA policy against the dissemination of purposely incomplete or
4 deceptive information intended to mislead patients and the utilization of state and federal funds
5 for potentially biased services provided by pregnancy counseling centers:
6

7 **Truth and Transparency in Pregnancy Counseling Centers H-420.954**

8 1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services
9 disclose information on site, in its advertising; and before any services are provided
10 concerning medical services, contraception, termination of pregnancy or referral for
11 such services, adoption options or referral for such services that it does and does not
12 provide, as well as fully disclose any financial, political, or religious associations which
13 such entities may have;
14

15 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical,
16 emotional, or financial means) by any agency offering crisis pregnancy services that
17 aim to discourage or interfere with a pregnant woman's pursuit of any medical
18 services for the care of her unplanned pregnancy;
19

20 3. Our AMA advocates that any entity providing medical or health services to
21 pregnant women that markets medical or any clinical services abide by licensing
22 requirements and have the appropriate qualified licensed personnel to do so and
23 abide by federal health information privacy laws, and additionally disclose their level
24 of compliance to such requirements and laws to patients receiving services;
25

26 4. Our AMA opposes the utilization of state and federal funding to finance such
27 entities offering crisis pregnancy services, which do not provide statistically validated
28 evidence-based medical information and care to pregnant women. (Modify Current
29 HOD Policy)
30

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses a timely issue with long-term impact that aligns with the priorities for this meeting. It is made urgent given the restrictions on physicians' abilities to provide abortions in multiple states, and the criminalization of these physicians providing their patients' healthcare.

Research shows that the issues surrounding pregnancy crisis centers (PCCs) and their coercive tactics have been continually worsening for an already vulnerable population. With the onset of the pandemic, many states placed last-minute, restrictive abortion bans, claiming these procedures were "non-essential", and thus countless women in vulnerable positions are forced to leave their states to seek timely and legal abortions. The AMA, as America's physicians' advocacy body, should prioritize this resolution to allow for this long-overdue healthcare reform that has only been exacerbated from the strain of the pandemic. The resolution aligns with the AMA's focus on combating racial discrimination, since women of color are more at risk for coercion from PCCs and are frequently targeted by these centers. PCCs and their advertisements are purposefully placed in low-income communities with large minority populations. It is more important now than ever before to ensure that these entities do not further impede minority women from receiving their necessary care. Women's health was under constant siege, even before the pandemic. During COVID-19, the PCC presence is becoming more pronounced and unfortunately the only option available to many women. Pregnancy does not stop for a pandemic, and neither should our efforts to protect and provide proper care for vulnerable women.

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RELEVANT AMA POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further
2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.

Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(N-21)

Introduced by: Medical Student Section

Subject: Banning the Practice of Virginity Testing

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, A “virginity exam” or “virginity test” is defined as an exam to assess the hymen for tears and inspect the vaginal walls and introitus for laxity for the purpose of determining whether a female has ever had sexual intercourse¹; and

Whereas, “Virginity testing” differs from female genital mutilation in that female genital mutilation involves either partial or full removal of or otherwise injuring external female genitalia and “virginity exams” do not¹⁵; and

Whereas, “Virginity testing” is a complex, culturally mediated practice which may be seen in some patient populations and may be poorly understood by U.S. clinicians²; and

Whereas, A survey conducted by The American College of Obstetricians and Gynecologists showed that 10% of obstetrician/gynecologists in the United States have been asked to perform “virginity testing,” and 34.5% of these physicians fulfilled these requests^{2,17}; and

Whereas, U.S. physicians who perform requested “virginity tests” report not knowing why they are performing the test, and almost none of them ask the patient or family why the test is being requested^{2, 13, 14}; and

Whereas, Little guidance has been published for clinicians who encounter requests for “virginity testing” in the clinical settings, and physicians who are asked to perform “virginity testing” report feeling they are not properly equipped to respond to these requests^{2, 13, 14}; and

Whereas, “Virginity testing” is an extremely invasive procedure that is often performed under coercion from a third party, such as family or spouses, and/or without patient consent, and by itself confers no physical, mental, or emotional health benefit to the patient undergoing the exam^{1,2, 7}; and

Whereas, “Virginity exams” may be physically harmful to the examinee as these exams may lead to hymenal damage, bleeding, or infection³; and

Whereas, Many anatomic variants of the hymen exist, including congenital abnormalities, natural changes in a woman’s lifespan, and injury resulting from non-sexual activities, and sexual intercourse or assault may not result in identifiable changes to hymenal tissue, thus “virginity exams” cannot reliably predict virginity status^{1,3,4,5,6,7}; and

Whereas, The Independent Forensic Expert Group has stated that “virginity testing” is inherently discriminatory because it correlates intercourse with immorality or criminal deviance and can only be performed on female-typical anatomy³; and

Whereas, “Virginity exams” have been shown to have negative psychological consequences on the examinee including but not limited to lower self-confidence, depression, and suicidal ideation, as well as lifelong effects such as post-traumatic stress disorder and anxiety^{1,2,3}; and

Whereas, There have been reported instances of “virginity exam” results leading to patient self-harm, murder, and physical violence against examinees^{1,3}; and

Whereas, In 2018, the World Health Organization and the United Nations publicly called for an end to the practice of “virginity testing,” as it is a violation of human rights on the basis of gender discrimination, inhumane treatment and punishment, and violation of privacy^{2,8}; and

Whereas, The American College of Obstetricians and Gynecologists supports efforts to eliminate the practice of “virginity testing” on the grounds of its medical invalidity and adverse effects to the examinee¹²; and

Whereas, A recent article in *BMJ Global Health* describes recommendations on educating and counseling patients about the lack of reliability and the possible harms of “virginity testing” through training community members, reading materials, and inclusion in other reproductive health discussion²; and

Whereas, The California Assembly (AB 1909) and the New York State Assembly (A08742) and Senate (S06879) have already introduced bills to prevent doctors from performing or supervising a “virginity examination”^{9,10,11}; and

Whereas, Our AMA has policies that promote trauma-informed care that avoids re-traumatizing patients and recognizes the effect of trauma on patients (H-515.952); and

Whereas, The AMA Code of Ethics (5.5 and 8.5) recognizes that “Physicians should only recommend and provide interventions that are medically appropriate--i.e., scientifically grounded” as well as that gender disparities in health care can stem from arbitrary evaluations that are not directly related to a patient’s clinical needs; therefore be it

RESOLVED, That our American Medical Association advocate for the elimination of the practice of virginity testing exams, physical exams purported to assess virginity (Directive to Take Action); and be it further

RESOLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution seeks to end the psychologically and physically dangerous practice of virginity testing. This practice recently came to the attention of the public when American rapper T.I. stated he regularly brings his daughter in for these exams. These tests have no scientific, medical, or legal validity, and they have shown to have harmful repercussions for the patients on which they are performed. Despite this, it is legal in all 50 states and there are no consequences for providers who perform such exams. Several institutions, such as ACOG and the United Nations, have already made statements supporting the elimination of this practice. Our delegation has already passed resolutions protecting women's rights, such as banning the practice of female genital mutilation, and this resolution would strengthen protections for this population. Women's medical rights have been particularly under attack in recent times, and this resolution poses an impactful, tangible way our AMA can take a stand for this group.

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RELEVANT AMA POLICY**H-525.980 Expansion of AMA Policy of Female Genital Mutilation**

Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support

groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.

CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Modified: Res. 9, A-12; Reaffirmed: BOT Rep. 15, A-17

H-60.938 Adolescent Sexual Activity

Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and

(b) supports the following principles for consideration in development of public policy:

- (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships;
- (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening;
- (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases;
- (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate;
- (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and
- (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

Res. 825, I-04; Modified: CSAPH Rep. 1, A-14

H-515.952 Adverse Childhood Experiences and Trauma Informed Care

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

- a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
- b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
- c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
- d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
- e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
- f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Res. 504, A-19; Appended: CSAPH Rep. 3, A-21

E-5.5 Medically Ineffective Interventions

At times patients (or their surrogates) request interventions that the physician judges not to be medically appropriate. Such requests are particularly challenging when the patient is terminally ill or suffers from an acute condition with an uncertain prognosis and therapeutic options range from aggressive, potentially burdensome life-extending intervention to comfort measures only. Requests for interventions that are not medically appropriate challenge the physician to balance obligations to respect patient autonomy and not to abandon the patient with obligations to be compassionate, yet candid, and to preserve the integrity of medical judgment.

Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician’s considered medical judgment about the risks and likely benefits of available options in light of the patient’s goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them.

Many health care institutions have promoted policies regarding so-called “futile” care. However, physicians must remember that it is not possible to offer a single, universal definition of futility.” The meaning of the term “futile” depends on the values and goals of a particular patient in specific clinical circumstances.

As clinicians, when a patient (or surrogate on behalf of a patient who lacks decision-making capacity) request care that the physician or other members of the health care team judge not to be medically appropriate, physicians should:

- (a) Discuss with the patient the individual’s goals for care, including desired quality of life, and seek to clarify misunderstandings. Include the patient’s surrogate in the conversation if possible, even when the patient retains decision-making capacity.
- (b) Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be provided unless the patient declines particular interventions (or the surrogate does so on behalf of a patient who lacks capacity).
- (c) Negotiate a mutually agreed-on plan of care consistent with the patient’s goals and with sound clinical judgment.
- (d) Seek assistance from an ethics committee or other appropriate institutional resource if the patient (or surrogate) continues to request care that the physician judges not to be medically appropriate, respecting the patient’s right to appeal when review does not support the request.
- (e) Seek to transfer care to another physician or another institution willing to provide the desired care in the rare event that disagreement cannot be resolved through available mechanisms, in keeping with ethics guidance. If transfer is not possible, the physician is under no ethical obligation to offer the intervention.

As leaders within their institutions, physicians should encourage the development of institutional policy that:

- (f) Acknowledges the need to make context sensitive judgments about care for individual patients.
- (g) Supports physicians in exercising their best professional judgment.
- (h) Takes into account community and institutional standards for care.
- (i) Uses scientifically sound measures of function or outcome.
- (j) Ensures consistency and due process in the event of disagreement over whether an intervention should be provided.

8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that

are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(N-21)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Sex work entails the provision of sexual services for money or goods, while sex
2 trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a
3 person for the purpose of a commercial sex act¹⁻³; and
4

5 Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter,
6 food, or money; survival sex is considered a subset of “sex work” since it does not involve the
7 force, fraud, or explicit coercion defined in sex trafficking⁴; and
8

9 Whereas, Consent is defined by the federal government as a freely given agreement to the
10 conduct at issue by a competent person, and consent is not constituted by lack of verbal or
11 physical resistance⁵⁻⁷; and
12

13 Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—
14 often problematically falls under the term “consensual” sex work; thus, consent in the realm of
15 sex work falls on a spectrum, rather than a binary definition⁵⁻⁷; and
16

17 Whereas, Globally, the three major policy approaches to sex trade regulation are (1)
18 criminalization, (2) full and partial decriminalization, and (3) legalization, and the US primarily
19 uses criminalization; and
20

21 Whereas, Criminalization of the selling of sex is associated with higher prevalence of unsafe
22 practices, such as not using condoms, higher rates of sexually transmitted infections (STIs),
23 lower likelihood of seeking healthcare for illness or injury related to sex work, and greater
24 likelihood of violence and rape of the individuals selling sex⁸⁻¹⁷; and
25

26 Whereas, Criminalization of the selling of sex is associated with higher rates of sexual
27 harassment, rape, and violence perpetrated by police against people selling sex¹⁷⁻²⁰; and
28

29 Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers
30 were four times more likely to report mental health issues, possibly due to increased risks that
31 come with illegal sex work such as assault and arrest²¹; and
32

33 Whereas, Because sex work is criminalized in the United States, many sex workers struggle to
34 obtain health insurance, leading to the majority being uninsured and paying out of pocket for
35 healthcare²²; and
36

37 Whereas, A systematic review of the literature estimates that 15-20% of men in the United
38 States have paid for sex at least once²³; and

Whereas, Surveys showing up to 37% of buyers believe that if they pay for sex, the sex worker is obligated to do anything they ask, and 19% admitting to having committed rape²⁴⁻²⁷; and

Whereas, In 2019, nearly 27,000 people, many of whom were parents, were arrested for prostitution and commercial vices in the United States, putting their children at an increased risk for depression, anxiety, antisocial behavior, drug use, and cognitive delays^{28,29}; and

Whereas, Individuals who sell sex for survival are often those from among the most vulnerable communities, such as undocumented immigrants, minority racial and ethnic populations, the economically marginalized, homeless or runaway youth, homeless populations in general and especially homeless LGBTQ+ populations, and transgender people^{20,30-39}; and

Whereas, In a nationwide study, 12% of trans women reported earning income through sex work, with higher rates among trans women of color, with 77% of these women reported intimate partner violence, 72% reported sexual assault, and 86% reported police harassment²⁰; and

Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, Amnesty International, and Human Rights Watch all recommend decriminalizing consensual sex work to improve access to health care for high risk populations, with the WHO specifying that decriminalization would help reduce HIV incidence^{17,40,41}; and

Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex, acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely-followed system of partial decriminalization and is employed in Sweden, Norway, Iceland, France, Ireland, Northern Ireland, Canada, and Israel⁴²; and

Whereas, In the Equality Model, people currently selling sex are offered voluntary participation in social services, and people found to be buying sex are offered voluntary participation programs to help them stop buying sex⁴²; and

Whereas, Partial decriminalization strategies such as the Equality Model are associated with a markedly lower rate of human trafficking, while full decriminalization and legalization are associated with increases in human trafficking to meet the increased demand for commercial sex, as well as increases in organized crime⁴²⁻⁴⁴; and

Whereas, Transition from criminalization to the decriminalization of the sale of sex in the Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a comparatively lower number of persons trafficked compared to surrounding nations using other policy systems^{42,45,46}; and

Whereas, An article in the *AMA Journal of Ethics* suggested the Equality Model, to be the most effective and ethical approach to addressing the issue of sex work and human rights violations⁴⁷; and

Whereas, Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population; therefore be it

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

1 RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex
2 in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel
3 keeping; and 3) support the expungement of criminal records of those previously convicted of
4 sex work, including trafficking survivors (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA support research on the long-term health, including mental health,
7 impacts of decriminalization of the sex trade. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

National and global disasters tend to lead to increases in human rights abuses and worsening circumstances for society's most vulnerable. Individuals who sell sex are often among the most vulnerable and marginalized members of society. As the voice of America's physicians, it is the AMA's duty to lead in protecting the most vulnerable. This resolution aims to allow the AMA to lead in recognizing the immense harms that the criminalization of people who sell sex causes to those people, their dependents, and the public's health. Research has demonstrated the positive impacts of decriminalizing the selling of sex while retaining criminalization of buying. Clearly, the selling of sex, in the same vein as drug use and abortion, has counterintuitive solutions that result in a better world for especially vulnerable patients.

Our AMA has been leading the charge with evidence-based solutions to many controversial issues in the past decades, and we believe that sex work is next. We urge this resolution's consideration and look forward to seeing the AMA join the WHO, UNFPA, UNAIDS, and many countries in improving the lives of many marginalized individuals, who have been particularly impacted by the pandemic.

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RELEVANT AMA POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Res. 009, A-17

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958

Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and “best practices”. Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.

Res. 14, A-15; Modified: Res. 003, I-17

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and

of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

Global HIV/AIDS Prevention H-20.898

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.

Res. 439, A-08; Modified: Res. 003, I-17

Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
 - a. An assessment tool for health care professionals
 - b. Online training in recognizing and responding to human trafficking in a health care context
 - c. Speakers and materials for in-person training
 - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

BOT Rep. 20, A-13; Appended: Res. 313, A-15

Human Trafficking / Slavery Awareness D-170.992

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Res. 015, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(N-21)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The World Health Organization has unequivocally defined infertility as a disease state
2 and a cause of disability¹; and
3

4 Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for
5 transgender men, which can suppress ovulation, and estrogen therapy for transgender women,
6 which can lead to impaired spermatogenesis and testicular atrophy^{2,3}; and
7

8 Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and
9 oophorectomy, which results in permanent sterility^{2,3}; and
10

11 Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of
12 respondents had received GAHT and 25% had undergone some form of GAS⁴; and
13

14 Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine
15 Society, and the American Society for Reproductive Medicine (ASRM) all recommend that
16 transgender individuals receive counseling regarding potential loss of fertility and future
17 reproductive options before initiating GAHT or undergoing GAS⁵⁻⁷; and
18

19 Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care
20 Act created protections barring insurance discrimination based on sexual orientation and gender
21 identity, although the current Administration has declined to defend this regulation and has been
22 deferential to states⁸⁻¹⁰; and
23

24 Whereas, Employers and states that have implemented coverage of transition-related services
25 have demonstrated minimal or no costs with vast immaterial/societal benefits^{10,11}; and
26

27 Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of
28 economic benefit, it is still difficult for transgender patients to obtain insurance coverage for
29 gender-affirming care, fertility counseling, and gamete preservation^{3,4,12}; and
30

31 Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with
32 specific requirements determined on a state-by-state basis^{12,13}; and
33

34 Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New
35 York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around
36 qualifying diagnoses is variable between states^{12,13}; and

Whereas, “Iatrogenic infertility” has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes¹²; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient’s physician (H-185.950)^{7,14}; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is “caused directly or indirectly by necessary medical treatments as determined by a licensed physician” (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage,” by addition to read as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Gender-affirming therapy, including gender-affirming hormone therapy and gender-affirming surgery, is vital to the physical and mental health of patients experiencing gender dysphoria. It is a necessary medical treatment, and any resulting complications should be considered iatrogenic. Our AMA supports payment for iatrogenic infertility (H185.990) and rights for gamete preservation for members of transgender and non-binary communities (H-65.956). However, patients who undergo gender-affirming therapy and have the complication of iatrogenic infertility are often denied coverage for fertility therapy. This resolution is a critical step to correcting this problem and eliminating discrimination against the LGBTQ+ community. The transgender and non-binary communities have suffered immensely this past year physically--due to increased occurrences of hate crimes--and emotionally---due to a record-setting amount of anti-LGBTQ legislation passed in 2021. The AMA has made recent commitments to advocate for health equity and justice, including the release of our Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, and this resolution represents an important step in furthering our advocacy in the health equity space.

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RELEVANT AMA POLICY**Right for Gamete Preservation Therapies H-65.956**

It is the policy of the AMA that (1): Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and (2) Our AMA supports the right of transgender or non-binary individuals

to seek gamete preservation therapies.
Res. 005, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Res. 150, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CMS Rep. 4, A-08 Appended: Res. 114, A-13 Modified: Res. 809, I-14

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122 A-08; Modified: Res. 05, A-16

Infertility Benefits for Veterans H-510.984

The AMA (1) Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; (2) Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; (3) Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; (4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

CMS Rep. 01, I-16; Appended: Res. 513, A-19

Storage & Use of Human Embryos- Ethics 4.2.5

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise

regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:

- (a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
- (b) Made available to other patients for purposes of reproduction.
- (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
- (d) Allowed to thaw and deteriorate.
- (e) Otherwise disposed of.

Under no circumstances should physicians participate in the sale of stored embryos

Issued: 2016

Assisted Reproductive Technology- Ethics 4.2.1

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. "Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(N-21)

Introduced by: Medical Student Section

Subject: Increased Recognition and Treatment of Eating Disorders in Minority Populations

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The DSM-V defines a binge-eating episode as “eating, in a discrete period of time, an
2 amount of food that is definitely larger than most people would eat in a similar period of time
3 under similar circumstances”¹; and
4

5 Whereas, The DSM-V defines the essential feature of binge-eating disorder (BED) as “recurrent
6 episodes [of] binge eating that must occur, on average, at least once per week for 3 months”¹;
7 and
8

9 Whereas, Binge eating disorder is the most prevalent eating disorder in the United States with a
10 lifetime prevalence of 2.8%²; and
11

12 Whereas, Recent evidence has shown significant differences in the prevalence of binge-eating
13 symptoms in non-Hispanic White populations and non-Hispanic Black populations³; and
14

15 Whereas, Rates of obesity, body satisfaction, and depression vary among ethnic groups
16 causing heterogeneity in the prevalence of eating disorders within these groups^{4,5}; and
17

18 Whereas, Some studies suggest that the increased risk of disordered eating in ethnic minority
19 adolescents may result from higher levels of stress due to minority status⁶; and
20

21 Whereas, It has been further suggested that among these adolescents, physical appearance is
22 viewed as a source of social capital, increasing their risk for engaging in unhealthy eating
23 behaviors as a means of changing their appearance⁶; and
24

25 Whereas, Research has shown that men and ethnic/racial minorities are significantly less likely
26 to seek help for binge eating disorders than women or non-Hispanic White people⁷; and
27

28 Whereas, Studies have documented lower rates of treatment for eating disorders among some
29 specific diverse populations due to differences in clinical presentation, differences in help-
30 seeking patterns, and clinician error or bias⁸⁻¹⁰; and
31

32 Whereas, Recent evidence from a study of Latina and Asian American women has shown that
33 “acculturative stress,” the adjustment and internal conflict that often occur as an individual
34 attempts to resolve cultural differences, may contribute to disordered eating¹¹; and
35

36 Whereas, A recent overview of Cochrane systematic reviews has shown that of all studied
37 psychosocial interventions, the cognitive behavioral approach was most effective for binge-
38 eating disorder, bulimia, nervosa, and night eating syndrome¹⁵; and

Whereas, For example, a qualitative study has shown that culturally adapted Cognitive Behavioral Therapy (CBT)-guided self-help has been well received and is a feasible treatment for Mexican American women with binge-eating disorder¹⁴; and

Whereas, Research suggests culturally sensitive CBT is both feasible and efficacious^{12,13}; and

Whereas, Binge-eating is the most prominent presentation of eating disorders, particularly in minority populations, but is not specified in current AMA policy despite less prevalent presentations such as weight restriction being specified; therefore be it

RESOLVED, That our American Medical Association amend Policy H-150.965, "Eating Disorders," by addition to read as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:

H-150.965 – EATING DISORDERS

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has had immense impacts on mental health, with mental health providers seeing enormous increases in demand for their services. During the pandemic, as well, we as a national and international community have had to face the massive impact of racial discrimination and mistreatment of people of marginalized racial groups. Medicine has particularly faced a reckoning, as the pandemic made and continues to make it abundantly clear that treatment of illnesses may differ solely based upon the race of the patient, and medical problems more that more profoundly affect some social, racial, or cultural groups are given less attention and less priority by the medical community. This is especially notable in the treatment of eating disorders, in which people from different cultures have been found to experience disordered eating differently, and people from certain cultural backgrounds have been shown to be less likely to receive appropriate treatment due to a lack of culturally appropriate care. Further, binge-eating disorder is the most prevalent eating disorder in the U.S., but it is left out of our AMA's policy considerations.

This resolution is important because it allows our AMA to make a small change policy change with a large impact, allowing us to recognize the importance of binge-eating disorder in a time of great mental health distress, and allowing us to address cultural and racial inequities in a time when medicine is having a reckoning with its own history of inexcusably unequal treatment.

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RELEVANT AMA POLICY

Eating Disorders H-150.965

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.

Res. 417, A-92, Appended: Res. 503, A-98, Modified and Reaffirmed: CSAPH Rep. 2, A-08, Reaffirmed: CSAPH Rep. 1, A-18

Eating Disorders and Promotion of Healthy Body Image H-150.928

Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

CSAPH Rep. 1, A-17

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health

concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res. 412, A-06, Appended: Res. 907, I-12, Reaffirmed in lieu of: Res 001, A-16

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

CMS Rep. 9, A-01, Reaffirmation: A-11, Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12, Reaffirmed in lieu of: Res. 804, I-13, Reaffirmed in lieu of: Res. 808, I-14, Reaffirmed: Res. 503, A-17, Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(N-21)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and
2 Immigration Services (USCIS) are as follows:

- 3
4 1. You must be a U.S. Citizen.
5 2. If you are unmarried, you must be at least 25 years old.
6 3. If you are married, you must jointly adopt the child (even if you are separated but
7 not divorced), and your spouse must also be either a U.S. citizen or in legal
8 status in the United States.
9 4. You must meet certain requirements that will determine your suitability as a
10 prospective adoptive parent, including criminal background checks,
11 fingerprinting, and a home study¹; and
12

13 Whereas, The federal government currently allocates funding for adoption and foster care to
14 states, which independently manage federal funds and have differing statutes concerning
15 eligibility to adopt or place a child up for adoption²⁻⁴; and
16

17 Whereas, Independent state-licensed child welfare agencies are contracted by each state to
18 provide foster care or adoption services⁵; and
19

20 Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how
21 “state-sanctioned discrimination against LGBT individuals who wish to raise children has
22 dramatically increased in recent years”⁶⁻⁷; and
23

24 Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of
25 children with LGBTQ individuals and same-sex couples and fourteen additional states lack
26 explicit protection for LGBTQ individuals concerning adoption rights⁵; and
27

28 Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283
29 total children in the U.S. foster care system with 125,422 children waiting to be adopted⁸; and
30

31 Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System
32 (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the
33 system⁸; and
34

35 Whereas, The longer a child is in foster care, the more likely that child is to move from one
36 foster placement to another, and the greater the risk that child experiences adverse childhood
37 events (ACEs), which may result in lasting negative social and emotional consequences⁹; and

1 Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster
2 care with no known internal or external problems show an increase in "total problem behavior" in
3 direct correlation with their number of placements¹⁰⁻¹²; and
4

5 Whereas, Frequent placement changes result in difficulty forming secure attachments with
6 foster parents, low self-esteem, and a negative relationship with academic growth¹⁰⁻¹²; and
7

8 Whereas, Per the Centers for Disease Control and Prevention, "Creating and sustaining safe,
9 stable, nurturing relationships and environments for all children and families can prevent ACEs
10 and help all children reach their full potential"¹³; and
11

12 Whereas, Recent social science literature supports that children living with same-sex parents
13 have equivalent outcomes compared to children with different-sex parents¹⁴; and
14

15 Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex
16 couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to
17 adopt children under age 18 compared to different sex couples¹⁵⁻¹⁶; and
18

19 Whereas, Current AMA Policy H-60.959 calls for the "comprehensive and evidence-based care
20 that addresses the specific health care needs of children in foster care" and supports the "best
21 interest of the child" as the most important criterion determining custody, placement, and
22 adoption of children;" and
23

24 Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of
25 their co-parenting partner but does not adequately address adoption rights of LGBTQ
26 individuals nor their limited eligibility or access to adoption, allowing for potential harm towards
27 children by narrowing the pool of qualified foster and adoptive homes; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for equal access to adoption
30 services for LGBTQ individuals who meet federal criteria for adoption regardless of gender
31 identity or sexual orientation (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA encourage allocation of government funding to licensed child
34 welfare agencies that offer adoption services to all individuals or couples including those with
35 LGBTQ identity. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses equal access to adoption for the LGBTQ community, a topic which is especially timely given the myriad of anti-LGBTQ+ legislation being passed or considered around the country. It is imperative that our AMA continue to decrease the stigma and discrimination not only for those children who have yet to be adopted, but for the innumerable children parented by same-sex couples today. Moreover, there is also a vital function of a more equitable and available adoption process for same sex couples. By expanding the federal requirements for non-discrimination in relation to same sex parents, great strides could be made in addressing the epidemic of LGBTQ youth homelessness. Furthermore, the Supreme Court recently heard arguments on this very topic, experts believe the Supreme Court is likely to rule in favor of the Catholic adoption agency and thus against LGBTQ+ same sex parents/couples. This resolution is thus urgent, time-sensitive, and a priority, and our AMA should act now to protect the rights and wellbeing of children and of LGBTQ+ parents and families.

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RELEVANT AMA POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National

Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children.

Sub. Res. 219, I-93Reaffirmed: BOT Rep. 28, A-03Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17

Partner Co-Adoption H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child.

Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

CSAPH Rep. 1, I-09; BOT Action in response to referred for decision; Res. 918, I-09;

Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973

It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.

Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Support of Human Rights and Freedom H-65.965

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

CBB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(N-21)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively
2 homosexual behavior to exclusively heterosexual behavior¹; and
3

4 Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2%
5 of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only
6 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or
7 bisexual²; and
8

9 Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual
10 sexual behavior as patients may not be willing to report their sexual histories accurately²; and
11

12 Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the
13 men who have sex with men (MSM) demographic³; and
14

15 Whereas, From 2010-2016, African American heterosexual women accounted for the second
16 highest incidence of HIV infection after MSM⁴; and
17

18 Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to
19 be the "bridge" through which HIV has been transmitted to black heterosexual men and women⁵-
20 ⁶; and
21

22 Whereas, Several studies have shown that African American MSMW may challenge targeted
23 HIV prevention approaches that focus explicitly on sexual orientation since this population may
24 not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize
25 gay community affiliation as foundations for HIV prevention⁵⁻⁶; and
26

27 Whereas, In 2017, the African American population and Hispanic population collectively
28 accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population³; and
29

30 Whereas, A report from the CDC concluded that increasing HIV prevention services among
31 heterosexuals at increased risk is important, especially among racial and ethnic groups
32 disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos⁷; and
33

34 Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended
35 with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are
36 at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces
37 the risk of sexual transmission of HIV by about 99% when taken daily⁸⁻⁹; and

1 Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million
2 additional individuals would benefit from being on it¹⁰⁻¹³; and

3
4 Whereas, Sixty-nine percent of the individuals that could benefit from PrEP are Black or
5 Hispanic, yet these individuals comprise only 4% of the individuals who are prescribed it¹¹⁻¹²;
6 and

7
8 Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the
9 United States, as people of color and women bear a high HIV burden, but have a
10 disproportionately limited uptake¹⁴; and

11
12 Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the
13 most frequently cited barrier to prescribing it being lack of knowledge¹⁵⁻¹⁶; and

14
15 Whereas, A 2018 study showed that medical students were unable to identify individuals at
16 highest risk of HIV acquisition and recommend PrEP accordingly¹⁷; and

17
18 Whereas, Educational interventions targeted at primary care physicians that focus on HIV
19 epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to
20 prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to
21 increase rates of PrEP prescribing when clinically indicated¹⁶; and

22
23 Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office
24 visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality,
25 contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as
26 early as age 11¹⁸⁻¹⁹; and

27
28 Whereas, It is considered a best practice in primary care settings to educate patients about all
29 the available options for preventing STIs, especially in sexually active adolescents and in adults
30 at increased risk for STIs¹⁸⁻¹⁹; and

31
32 Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative
33 individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients^{8,15}; and

34
35 Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-
36 white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP
37 uptake, was suggestion to initiate PrEP by a healthcare provider¹⁴; and

38
39 Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-
40 350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and
41 ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective
42 medical diagnosis and treatment"; and

43
44 Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the
45 consistency and equity of care for all persons" and "supports research to identify the most
46 effective strategies for educating physicians on how to eliminate disparities in health outcomes
47 in all at-risk populations"; and

48
49 Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV
50 prevention and treatment nor proposes a specific intervention to reduce such disparities;
51 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure
2 Prophylaxis (PrEP) for HIV,” by addition to read as follows:

3
4 Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

- 5 1. Our AMA will educate physicians, physicians-in-training, and the public about the
6 effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical
7 Practice Guidelines.
8 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
9 3. Our AMA supports the removal of insurance barriers for PrEP such as prior
10 authorization, mandatory consultation with an infectious disease specialist and
11 other barriers that are not clinically relevant.
12 4. Our AMA advocates that individuals not be denied any insurance on the basis of
13 PrEP use.
14 5. Our AMA encourages the discussion of and education about PrEP during routine
15 sexual health counseling, regardless of a patient’s current reported sexual
16 behaviors. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution is pivotal if the U.S. wishes to reach or even come close to its set goal of eliminating HIV in our country by 2030. The HIV/AIDS pandemic has continued unabated and even increased during the COVID-19 pandemic. HIV researchers and infectious diseases physicians have predicted that the decreased availability of HIV treatment during the COVID-19 pandemic may set back our progress against HIV by multiple years. HIV most profoundly affects marginalized communities, and these communities are also the most likely to have barriers to access to preventive measures, especially PrEP.

This resolution aims to reduce existing disparities through universal PrEP counseling. Universal PrEP counseling would work to address the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ+ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people, people of color, and low-income LGBTQ+ individuals. This resolution represents a way to use patient-centered care to address an urgent and rapidly growing problem: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk

for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation: A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18.

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation: A-11; Reaffirmation: A-12; Reaffirmation: A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
 - a. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
 - b. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
 - c. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

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

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use. Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.

2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission. Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.

b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;

c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;

d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;

e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(N-21)

Introduced by: Medical Student Section

Subject: Using X-Ray and Dental Records for Assessing Immigrant Age

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-
2 rays, which together are compared to growth charts to determine the age of an individual¹; and
3

4 Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs,
5 and dental x-rays may not correlate with the true chronological age of an individual due to
6 population and geography-specific factors, including nutritional intake, environmental exposure,
7 and genetics to such an extent that the Centers for Disease Control and Prevention (CDC)
8 recommends against using hand-wrist radiographs to determine the age of refugees¹⁻⁵; and
9

10 Whereas, International records highlight the wide variety in growth charts utilized country to
11 country, in part due to different genetics, nutrition, medical conditions, and environmental
12 exposures^{6,7,8}; and
13

14 Whereas, The Department of Homeland Security (DHS) and the Department of Health and
15 Human Services (HHS) will request new skeletal and dental x-ray imaging to establish the age
16 of an individual crossing the border⁹; and
17

18 Whereas, According to Food and Drug Administration recommendations, performing x-rays on
19 children comes with greater risk of radiation-related illness and should only be used to answer a
20 clinical question or to guide treatment¹⁰; and
21

22 Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement, which
23 is part of HHS, states that medical images may be used only when no other means of verifying
24 chronological age exist^{9,11}; and
25

26 Whereas, The DHS handbook states that acceptable documentation to verify chronological age
27 can include official government-issued documents such as a birth certificate, other
28 governmental records, a baptismal certificate, school records, medical records, or other
29 objective documentation with a date of birth listed⁹; and
30

31 Whereas, If the immigrant/refugee does not have their birth certificate, the DHS handbook
32 states that affirmative steps should be taken to contact the refugee's home country's relevant
33 record keeping department to verify their birth date⁹; and
34

35 Whereas, The DHS handbook directs immigration officers to accept statements by the person in
36 question, their family members, other people who know the person as verifying evidence⁹; and

1 Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration
2 and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for
3 child age determination and has since decreased their use of age determination exams ^{12,13};
4 and
5

6 Whereas, In 2018, ICE decreased the number of age determination exams it used to less than
7 50; meanwhile, HHS increased its utilization of the exams for those in the care of the ORR to
8 almost 700, almost double the number granted to both agencies in each of the prior two years¹³;
9 and
10

11 Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are
12 held in adult detention centers while waiting for their cases to be heard and therefore are not
13 held in the least restrictive setting, in violation of the federal government's promise to do so in
14 the Flores Agreement and further restricting their rights ¹⁴; and
15

16 Whereas, Attorneys representing minors report that their clients' supporting documentation was
17 not used and were instead placed in adult detention centers solely based on x-ray images for
18 months until federal judges ruled that ICE and HHS could not classify their immigrant clients as
19 adults based solely on imaging¹⁵; and
20

21 Whereas, As an example, one 19-year-old woman immigrating to the U.S. on a fiancée visa was
22 incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released
23 to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months¹⁶; and
24

25 Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare
26 services provided to minor immigrants, both in detention and those held at border patrol
27 stations; and
28

29 Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit
30 U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law
31 enforcement agencies from utilizing information from medical records to pursue immigration
32 enforcement actions against patients who are undocumented; therefore be it
33

34 RESOLVED, That our American Medical Association support discontinuation of the use of non-
35 medically necessary dental and bone forensics to assess an immigrant's age. (New HOD
36 Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has revealed some of the great inequities faced by immigrants and refugees, especially immigrant and refugee children, seeking safety in the U.S. This resolution addresses a specific healthcare problem that pediatric migrants and refugees face when crossing our borders. Dental and bone X-rays are often used inappropriately in determining an immigrant person's age, which physicians have said is inaccurate and could result in inaccurate treatment of the children. Further, physicians and researchers have raised alarms that this is a harmful practice that subjects children to the unnecessary use of medical imaging, unnecessarily increasing their radiation exposure. As the voice of America's physicians, our AMA should prioritize protections for particularly vulnerable and marginalized members in our society, including immigrants and refugees and especially children, during this ongoing pandemic. This resolution calls for timely action taken on behalf of an incredibly vulnerable population and thus asks the House's consideration.

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RELEVANT AMA POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2)

condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

Res. 013, A-19

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(N-21)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, School-related arrests and juvenile justice referrals have been associated with school
2 disengagements, lower graduation rates, increased dropout rates, and increased involvement in
3 the school-to-prison pipeline^{1, 2}; and
4

5 Whereas, School-related arrests and juvenile justice referrals disproportionately target Black
6 students, Latinx students, male students, and students with physical or mental disabilities^{3, 4, 5};
7 and
8

9 Whereas, Research on the effectiveness of school resource officer programs is limited, and fails
10 to make a strong case for harsh discipline programs that include referral to law enforcement⁶;
11 and
12

13 Whereas, School-based mental health efforts have been successful in identifying those in need
14 of mental health services, bolstering academic functioning, and improving patterns of behavior⁷;
15 and
16

17 Whereas, Educators, nurses, and counselors can play a key role in fostering protective
18 environments for children and identifying students who may need additional support, in contrast
19 to school resource officers^{8, 9}; and
20

21 Whereas, School-based mental health professionals report ever-increasing workloads and
22 responsibilities that include disciplinary roles^{10, 11}; and
23

24 Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental
25 health, or social issues because they do not feel that their disclosure will be kept private,
26 possibly affecting their academic or conduct standing¹²; and
27

28 Whereas, The American School Counselor Association urges that “school counselors maintain
29 non-threatening relationships with students to best promote student achievement and
30 development” and states that school counselors are neither “disciplinarians” or “enforcement
31 agent[s] for the school”¹³; and
32

33 Whereas, The National Association of School Nurses states that school nurses should facilitate
34 an “environment that values connecting students, families, and the community in positive
35 engagement” characterized by “safety and trust where students are aware that caring, trained
36 adults are present and equipped to take action on their behalf”¹⁴; and

1 Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based
2 implementation framework focusing on prevention and intervention strategies that support the
3 academic, social, emotional, and behavioral competence of students at all levels of education¹⁵;
4 and

5
6 Whereas, PBIS promotes prevention of student misbehavior by having students experience
7 "predictable instructional consequences for problem behavior without inadvertent rewarding"
8 while educators provide "clear and predictable consequences for problem behavior and
9 following up with constructive support to reduce the probability of future problem behavior"¹⁵;
10 and

11
12 Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344
13 elementary students to reduce concentration and behavioral problems, and increase social-
14 emotional functioning and prosocial behavior¹⁶; and

15
16 Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior,
17 and academics while decreasing office discipline referrals, in-school suspensions, and out-of-
18 school suspensions^{17, 18}; and

19
20 Whereas, Mental Health America and the American Academy of Pediatrics have recognized the
21 detrimental effects of "zero tolerance" policies and have advocated for school wide PBIS as an
22 alternative^{19, 20}; and

23
24 Whereas, AMA policy H-60.919 includes support for "school discipline policies that permit
25 reasonable discretion and consideration of mitigating circumstances when determining
26 punishments," but is largely focused on determination of punishment rather than prevention of
27 misbehavior; and

28
29 Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA
30 policy H-60.902 addresses the need for policy ensuring proper qualification and training for
31 school resource officers, but do not delineate if or how school-based health professionals
32 should participate in school disciplinary roles; therefore be it

33
34 RESOLVED, That our American Medical Association support evidence-based frameworks in
35 K-12 schools that focus on school-wide prevention and intervention strategies for student
36 misbehavior (New HOD Policy); and be it further

37
38 RESOLVED, That our AMA support the inclusion of school-based mental health professionals in
39 the student discipline process. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses an important policy gap by expanding on current policies concerning school discipline. This issue is particularly urgent and timely as schools are transitioning back to in-person attendance after more than a year of virtual learning. We ask the AMA to work with education stakeholders to determine appropriate roles for mental-health professionals in schools, with particular respect to disciplinary processes. Children are returning from a year at home, under the constant threat of a dangerous disease, when many likely lost family members; children will undoubtedly find themselves acting out more and in need of more mental health support. This resolution, in contrast, focuses on interventions that can help prevent student misbehavior and the prioritization of their behavioral and mental health outcomes.

As children begin to return to “normal” school settings in this ongoing pandemic, it is vital that we take proactive steps to help them be successful and to prevent them from experiencing further setbacks to their education and social and individual development.

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RELEVANT AMA POLICY

Juvenile Justice System Reform, H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

School-Based and School-Linked Health Centers, H-60.921

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

CSAPH Rep. 1, A-15

Adolescent Health, H-60.981

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.

Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07;

Reaffirmed CSAPH Rep. 01, A-17

Providing Medical Services Through School-Based Health Programs, H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

Improving Pediatric Mental Health Screening, H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Access to Mental Health Services, H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

- (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
- (2) improving public awareness of effective treatment for mental illness;
- (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
- (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
- (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making

proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.

CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

School Resource Officer Qualifications and Training, H-60.902

Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Res. 926, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(N-21)

Introduced by: Women Physicians Section

Subject: Gender Equity and Female Physician Work Patterns During the Pandemic

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Studies show that women carry more responsibility than their male counterparts for
2 personal and family life^{1, 3}; and
3

4 Whereas, A study following a cohort of faculty from the 1995 National Faculty Survey through
5 17 years showed persistent gender disparities in rank, retention, and leadership positions;² and
6

7 Whereas, Prior to the pandemic, due to the culture of medicine, many female physicians made
8 adjustments in their professional roles, including “part-time status, despite the known limitations
9 on professional progression, career advancement, and economic potential. These adjustments
10 further propagate gender inequities and the persistent compensation gap female physicians
11 experience;”³ and
12

13 Whereas, The COVID-19 pandemic is requiring additional adjustments to the professional lives
14 of physicians and many of these adjustments will be made disproportionately by female
15 physicians due to childcare and pregnancy;⁴ and
16

17 Whereas, Since the pandemic, there has been a decrease in the percentage of physicians
18 working full-time, a rise in the percentage who were laid off, and an increase in changes in
19 physicians’ usual activities. The decline in the percentage of parents with preschool-aged
20 children among only female physicians may suggest a disproportionate uptake of childcare
21 responsibilities among female physicians;⁵ and
22

23 Whereas, In a recent survey, female scientists reported a decline in research time relative to
24 male colleagues during the COVID-19 pandemic, but the most significant factor was having a
25 young dependent less than 6 years of age;⁶ and
26

27 Whereas, One in five physicians experienced a financial cut or furlough because of the
28 pandemic, but there is limited data on how these cuts and furloughs have impacted female
29 physicians specifically⁷; therefore be it
30

31 RESOLVED, That our American Medical Association advocate for research on physician-
32 specific data analyzing changes in work patterns and employment outcomes among female
33 physicians during the pandemic including, but not limited to, understanding potential gaps in
34 equity, indications for terminations and/or furloughs, gender differences in those who had
35 unpaid additional work hours, and issues related to intersectionality (Directive to Take Action);
36 and be it further
37

38 RESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles
39 affecting female physicians and medical students during the pandemic. (Directive to Take
40 Action)

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

Received: 10/07/21

AUTHORS STATEMENT OF PRIORITY

The pandemic has shed light on many inequities in our healthcare system. Some of these inequities deal with access to care and longstanding untreated health conditions in vulnerable and underrepresented populations. However, the pandemic has also highlighted the ways women are treated differently in our industry. Women physicians have had to juggle more responsibilities related to childcare and homeschooling as well as sometimes being the caregiver for aging parents. Due to these added barriers and inflexibility in workdays and environment, some women have been passed over for promotions, not allowed to work from home, or even fired. The pandemic is still underway, but even once it has passed, this time in history will have withstanding impacts on women physicians and their futures. Therefore, this resolution is timely and pertinent to support women physicians now to influence their professional and leadership trajectories.

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

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.

Citation: BOT Rep. 27, A-19

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

- a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as

to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13;

Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17;

Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(N-21)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Support for Safe and Equitable Access to Voting

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and
2 residents to vote by mail¹; and
3

4 Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot
5 by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept
6 risk or fear of COVID-19 infection as a valid reason²⁻⁴; and
7

8 Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January
9 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over
10 198,000⁵⁻⁶; and
11

12 Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking,
13 with a prevalence of 14% of adults in 2018⁷; obesity, with a prevalence of 42% of adults in
14 2017-2018⁸; and diabetes with a prevalence of 10% of adults in 2018⁹; and
15

16 Whereas, Public health experts continue to warn governments and the public to prepare for
17 future pandemics which may arise similarly to the COVID-19 pandemic¹⁰⁻¹²; and
18

19 Whereas, A study of the 2020 Wisconsin primaries found “a statistically and economically
20 significant association between in-person voting and the spread of COVID-19 two to three
21 weeks after the election”¹³; and
22

23 Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with
24 reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle
25 closures, limited in-person interactions, and the cancellation of many large public gatherings¹⁴;
26 and
27

28 Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to
29 fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and
30 longer waiting times in the 2020 primaries¹⁵⁻¹⁷; and
31

32 Whereas, Following widespread adoption of community mitigation measures to target SARS-
33 CoV-2, influenza rates among sentinel countries in the southern hemisphere have been
34 dramatically lower than historical averages during their peak influenza season¹⁸, suggesting the
35 continuance of such measures past the COVID-19 pandemic could contribute to a reduction in
36 the incidence of influenza; and
37

38 Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability¹⁹; and

1 Whereas, In the 2016 general election, the US Government Accountability Office found that
2 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in
3 unsafe or insecure conditions for these voters²⁰; and
4

5 Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse
6 absentee balloting and permanent absentee voting increases voter turnout among citizens with
7 disabilities²¹; and
8

9 Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure
10 that likely has increased in the years since given greater life expectancy among
11 immunosuppressed adults due to advancements in medical management and new indications
12 for immunosuppressive treatments²²; and
13

14 Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote
15 share²³; and
16

17 Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately
18 23.1% of all votes cast in the 2018 general election having been by mail²⁴; and
19

20 Whereas, Members of the military have voted-by-mail in some form since the Civil War, and
21 citizens living abroad also submit their ballots by mail²⁵⁻²⁷; and
22

23 Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately
24 increases overall average turnout rates, in line with previous estimates²³; and
25

26 Whereas, Numerous national and local government officials have expressed opposition to
27 expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection^{24,28-32}; and
28

29 Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one
30 study finding only 0.0025% of votes being flagged as possible cases of election fraud in the
31 2016 and 2018 general elections³³; and
32

33 Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel
34 the in-person proceedings of the 2020 Interim Meeting while preserving the voting process
35 through transition to an innovative virtual format³⁴; and
36

37 Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will
38 continue to be an urgent risk for voters and poll workers in subsequent elections like federal
39 runoff elections conducted in Georgia and Louisiana and local elections conducted in Spring
40 2021³⁵⁻³⁸; therefore be it
41

42 RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting
43 as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of
44 infectious disease transmission by measures including but not limited to:

- 45 (a) extending polling hours;
- 46 (b) increasing the number of polling locations;
- 47 (c) extending early voting periods;
- 48 (d) mail-in ballot postage that is free or prepaid by the government;
- 49 (e) adequate resourcing of the United States Postal Service and election operational
- 50 procedures;
- 51 (f) improve access to drop off locations for mail-in or early ballots (New HOD Policy);
- 52 and be it further

- 1 RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order
2 to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New
3 HOD Policy)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The AMA missed an opportunity to have a more significant voice during the last special election and continues to be left out of the important discussion regarding voting as a right, the challenges associated with in-person voting, and its contribution to the social determinants of health. Discussion of this resolution is timely for state and local elections and, if we are to be prepared for 2022, we must pass this now to give our Board and staff time to strategize. The asks are appropriately narrow in scope, pertinent, and relevant to the large majority of our patients and colleagues.

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RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to

report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.

Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

H-65.971 Mental Illness and the Right to Vote

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

H-295.953 Medical Student, Resident and Fellow Legislative Awareness

1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.

2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.

3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.

4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Res. 14, A-91; Reaffirmed: Sunset Report, I-01; Appended: Res. 317, A-10; Appended: Res. 307, A-15

G-615.103 Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

Res. 608, A-17

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may

Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

Citation: Res. 8, A-11; Reaffirmed: CEJA Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(N-21)

Introduced by: Resident and Fellow Section

Subject: Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, The American Association of Physical Anthropologists believes that “race does not have its roots in biological reality, but...has become a social reality that structures societies and how we experience the world. In this regard, race is real, as is racism, and both have real biological consequences ”;¹ and

Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as belonging to a unique, independent racial category in the U.S. Census data, and instead they are aggregated under “White”;² and

Whereas, MENA designation is not included in the National Institute of Health’s racial and ethnic categories, and thus is not required to be considered in any federally-funded research;³ and

Whereas, MENA is not included as a race category nor an ethnicity category routinely collected in survey and demographic data in the U.S.;^{4,5} and

Whereas, There are discrepancies in the total population of MENA populations across the US due to inaccurate identification and aggregation;^{2,5} and

Whereas, There is limited research about the healthcare of populations from the MENA region in U.S. epidemiological and public health literature and existing literature is focused on ethnic enclaves which may not be reflective of the community as a whole;^{4,6} and

Whereas, Americans of MENA descent disproportionately constitute immigrants from the past two decades, share a set of cultural norms, and face recent marginalization and discrimination towards this population;^{4,5,7} and

Whereas, MENA populations have different risk factors and social determinants including high rates of immigration and individuals seeking asylum;^{6,8,9} and

Whereas, To the knowledge of the authors there has never been a prospective study examining the health needs of MENA communities in the U.S.;⁴ and

Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some MENA populations due to higher rates of consanguineous marriages, most commonly with first cousins;¹⁰ and

Whereas, Discrimination against MENA populations in the U.S. increased dramatically after September 11th, 2001, including increased harassment, discrimination, violence, and targeted hate crimes that have resulted in worsening health outcomes in this population;^{6,11,12} and

Whereas, MENA populations in the US suffer from a high rate of serious psychosocial distress compared to the general population which may be in part due to their immigrant status;¹³ and

Whereas, Classifying MENA populations as “White” has led to their “cultural invisibility” and perpetuates a cycle of undocumented health disparities⁵ that greatly affects funding for health-related research, targeting of effective and personalized healthcare, and prevents patient-centered care and engagement;^{4,5,6,10,14} and

Whereas, Including a race identifier for MENA populations on all medical records will increase the representation and visibility of the population, and increases the research and attention to the medical and public health needs of this community;^{4,5,6,15} and

Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that “it is optimal to use a dedicated ‘Middle Eastern or North African’ response category,” the Census Bureau declined to include a MENA identifier in the 2020 Census;¹⁶ and

Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it vitally important in the promotion of medicine and public health, and the Census has acknowledged that its inaccuracies in collection of race and ethnicity data act as a barrier to the Census’ utility and accuracy;¹⁷ and

Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of data, in order to appropriately target research, preventive measures, and healthcare engagement; therefore be it

RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate racial category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

In light of the increasing number of individuals coming to this country from the Middle East and North Africa, it is our professional responsibility to identify the specific medical concerns relevant to this disadvantaged group. The AMA has policy on disaggregation of data for other groups, including Asian-Americans and Pacific Islanders (AAPI), and this important policy would build on this foundation in order to help the AMA advocate for our patients, especially in addressing within-group health disparities.

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RELEVANT AMA POLICY

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. 2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17Appended: Res. 403, A-19

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

Citation: Res. 03, I-19

Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996

Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information

obtained from the patient, always respecting the personal privacy and communication preferences of the patient.

Citation: Res. 4, I-83Reaffirmed: CLRPD Rep. 1, I-93Reaffirmed: CSA Rep. 8, A-05Modified: CSAPH Rep. 1, A-15Modified: Res. 03, I-19

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.

2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(N-21)

Introduced by: Iowa

Subject: Recognizing and Remedying “Structural Urbanism” Bias as a Factor in Rural Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Rural Americans’ health disparities are significant and unacceptable, with mortality
2 rates 23% higher, and preventable hospitalizations 40% higher-- across all racial and age
3 groups; and
4

5 Whereas, The differences in rural vs. urban health measures have been worsening over the last
6 30 years; and
7

8 Whereas, The percent of physicians who practice in rural areas is about 11%, despite 20% of
9 Americans living in rural America; and
10

11 Whereas, Health care research (Johnston, et al.¹) has shown that the biggest reason for worse
12 rural mortality and preventable hospitalization rates is the shortage in “local-area supply of
13 specialists, which explained 55% of the differences in hospitalization rates and 40% of the
14 difference in mortality rates”; and
15

16 Whereas, Medicare’s physician geographic payment policy since 1992 (developed under the
17 direction of consultants from the Urban Institute) has chronically discriminated against rural
18 physicians, with the current policy adjusting rural physician E&M payments as much as 25-30%
19 lower than some urban areas, and adjusting rural diagnostic testing payments 50-60% lower
20 than some urban areas; and
21

22 Whereas, Another research group (Probst, et al.²) wrote that “rural health disparities are due in
23 part to declining healthcare provider availability and accessibility in rural communities” and
24 “these problems are exacerbated by structural urbanism” ... a bias which “systematically
25 shortchanges rural areas”. They also suggested that “current models of health care funding...
26 are innately biased in favor of large populations” and “until this bias is recognized, the
27 development of viable models of care across the rural-urban continuum cannot move forward”;
28 and
29

30 Whereas, In the CME report on Rural Health Physician Workforce Disparities, telehealth was
31 touted as one way to remedy rural health disparities, and the CME recognized some of the
32 telehealth barriers such as the current site of service Medicare payments. The problem is that
33 without geographic equity in telehealth payments there would be no financial incentive for urban
34 physicians to serve rural vs. urban patients, and keeping Medicare’s geographically adjusted
35 payments unchanged would give incentives for rural physicians to receive higher telehealth
36 payment for urban patients; and

Whereas, National telehealth services who serve rural and urban hospitals and physician groups do not give geographic discounts for their services, which means there is a national, not a local, "market price" for teleservices, unlike Medicare's geographic payment policy which shortchanges rural physicians; therefore be it

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called "Structural Urbanism," has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America's health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the identification and remediation of health disparities, and this resolution asks for action to help address a major, unacceptable disparity in health care access and outcomes, with identification of causes for the 23% higher mortality and 40% higher preventable hospitalizations that could impact 60 million rural Americans.

The resolution is also timely because the COVID-19 pandemic has highlighted the need for telehealth legislation to help improve access to care to all Americans, especially underserved rural residents. The telehealth resolution would ensure that increased access, which telehealth legislation would bring, is not a hollow promise.

References:

1. Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
2. Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Geographic Practice Cost Index D-400.985

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

Citation: (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12; Reaffirmation: I-12; Reaffirmation I-13)

Elimination of Payment Differentials Between Urban and Rural Medical Care H-240.971

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.

Citation: Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Equal Pay for Equal Work D-400.989

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

Access to and Quality of Rural Health Care H-465.997

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

Citation: CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

Enhancing Rural Physician Practices H-465.981

The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

Citation: CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and

Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01;

Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18;

Appended: Res. 318, A-19

Rural Health H-465.982

The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.

Citation: (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Economic Viability of Rural Sole Community Hospitals H-465.979

Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

Citation: (CMS Rep. 3, A-15)

Closing of Small Rural Hospitals H-465.990

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

Citation: (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10;

Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(N-21)

Introduced by: Louisiana

Subject: Free Speech and Civil Discourse in the American Medical Association

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, On June 1, 2021, Dr. Russ Kridel, Chair, AMA Board of Trustees, issued a message
2 to the members of the American Medical Association House of Delegates regarding certain
3 recent events pertaining to discussion of the AMA's *Organizational Strategic Plan to Embed*
4 *Racial Justice and Advance Health Equity*; and
5

6 Whereas, As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the
7 same professionalism that we try to exhibit daily as practicing physicians". However, many at
8 recent meetings of the AMA House, particularly those held virtually, we have witnessed some
9 loss of professionalism in regard to comments regarding the strategic plan. Some members of
10 our House are being personally attacked and threatened by others for their thoughts and ideas.
11 Name calling, unsettling calls to family members, and other unprofessional communications
12 have occurred;" and
13

14 Whereas, In light of recent deterioration in civility and professionalism in policy debate and
15 discussion at the American Medical Association, the Louisiana Delegation to the AMA
16 developed and submitted Late Resolution 1003 at the June meeting calling for enhanced
17 standards of dignity, respect, tolerance and professionalism in AMA policy debate and
18 discussions; and
19

20 Whereas, Louisiana-submitted Late Resolution 1003 was recommended for acceptance as
21 business of the House of Delegates by the AMA HOD Committee on Rules and Credentials,
22 and was recommended as meeting the priority threshold and recommended for acceptance as
23 business by the AMA HOD Resolution Committee; and
24

25 Whereas, The AMA House of Delegates refused to consider Late Resolution 1003, thereby
26 failing to address the recent deterioration in civility and professionalism characterizing AMA
27 policy debate and discussion; therefore be it
28

29 RESOLVED, That it be the policy of our American Medical Association that:
30

31 Our American Medical Association unequivocally commits to truly open discourse,
32 debate, exchange of ideas, and argument;
33

34 Our American Medical Association unequivocally commits to a culture which
35 recognizes the inherent dignity and worth of its members, which resolves that
36 freedom of expression and civility must coexist, and where those who disagree will do
37 so without enmity;

1 Our American Medical Association unequivocally commits to the principle that
2 dissenting and unpopular voices must be afforded the opportunity to be heard;
3

4 Our American Medical Association unequivocally commits that members of the
5 American Medical Association of different faiths, philosophies, and persuasions may
6 speak their minds and honor their deepest convictions without fear of punishment or
7 retaliation;
8

9 Our American Medical Association unequivocally commits that the mere exposure to
10 ideas that some may find offensive is not an act of violence or hatred;
11

12 Our American Medical Association unequivocally commits to a prohibition of the
13 listing of people or organizations to be regarded as unacceptable, untrustworthy,
14 excluded, or avoided based on ideological positions or differences;
15

16 Our American Medical Association unequivocally commits that ideological
17 demonization of opponents to block debate and to silence disagreement in the
18 proceedings of the American Medical Association is unprofessional conduct subject to
19 appropriate disciplinary action;
20

21 Our American Medical Association unequivocally commits that defamation, obscenity,
22 intimidation, threats, and incitement to violence, have no place in the proceedings of
23 the American Medical Association, and if exhibited are unprofessional conduct subject
24 to appropriate disciplinary action. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

¹ Russ Kridel, "A Communication from the Board Chair," email of June 1, 2021 (copy on file with author).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(N-21)

Introduced by: Louisiana

Subject: Prohibition of Racist Characterization Based on Personal Attributes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Recent events at the American Medical Association have resulted in that entity
2 publicly promulgating statements that are racially exclusive and racially characterizing, as
3 contained in the AMA *Organizational Strategic Plan to Embed Racial Justice and Advance*
4 *Health Equity*ⁱ (hereinafter *the Equity Strategic Plan*); and

5
6 Whereas, *The Equity Strategic Plan* endorses a racially exclusive definition of racism: Racism,
7 as defined by Camara Jones, MD, MPH, PhD, is a “system of structuring opportunity,” which
8 assigns value based on race, disadvantaging people of color while offering advantage to
9 whites.... (P. 15); and

10
11 Whereas, *The Equity Strategic Plan* includes the following racially characterizing statements:
12 We must develop a critical consciousness that seeks truth and acknowledges the historical
13 realities that powerful organizations and structures, rooted in white patriarchy and affluent
14 supremacy such as the AMA, have both intentionally and unintentionally made invisible (p. 5).
15 White supremacy, constantly adapting to legal and cultural challenges, persists in part by the
16 way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy,
17 and the privilege it gives them (p. 13). Locating white supremacy in individuals, rather than in
18 structures, is how the shared commitment to white ignorance preserves one’s sense of self
19 while allowing oppressive structures to persist (p. 14); and

20
21 Whereas, Attempts by the Louisiana Delegation to the AMA to have the AMA House of
22 Delegates adopt policy, at its June 2021 Special Meeting, that prohibits racist characterization of
23 person or groups of persons based on personal attributes were unsuccessful; therefore be it

24
25 RESOLVED, That it be the policy of our American Medical Association that no person or group
26 of persons shall be considered or characterized as racist based on personal attributes of race,
27 color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin,
28 age, disability, or genetic information. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

ⁱ American Medical Association, *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity*, (Chicago: American Medical Association, 2021), <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Discrimination Against Patients by Medical Students H-295.865

Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

Citation: (Res. 1, A-13)