

## DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its November 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

### AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (N-21)

Report of Reference Committee on Amendments to Constitution and Bylaws

Heidi Dunniway, MD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:

2  
3 **RECOMMENDED FOR ADOPTION**

- 4  
5 1. Board of Trustees Report 5 – Terms and Languages in Policies Adopted to  
6 Protect Populations from Discrimination and Harassment  
7 2. Board of Trustees Report 11 – National Guidelines for Guardianship  
8 3. Board of Trustees Report 13 – Study of Forced Organ Harvesting by China  
9 4. Board of Trustees Report 15 – Opposing Attorney Presence at and/or Recording  
10 of Independent Medical Examinations  
11 5. Board of Trustees Report 16 – Research Handling of De-Identified Patient  
12 Information  
13 6. Board of Trustees Report 20 – Specialty Society Representation in the House of  
14 Delegates Five-Year Review  
15 7. Council on Constitution and Bylaws Report 1 – Further Action on Bylaw 7.5.2  
16 8. Council on Constitution and Bylaws Report 2 – Recission of Bylaws Related to  
17 Run-off Elections  
18 9. Council on Constitution and Bylaws Report 3 – AMA Women Physicians Section:  
19 Clarification of Bylaw Language  
20 10. Council on Ethical and Judicial Affairs Report 1 – Short-term Medical Service  
21 Trips  
22 11. Council on Ethical and Judicial Affairs Report 2 – Amendments to Opinions  
23 1.2.11, “Ethical Innovation in Medical Practice”; 11.1.2, “Physician Stewardship of  
24 Health Care Resources”; 11.2.1, “Professionalism in Health Care Systems”; and  
25 1.1.6, “Quality”  
26 12. Speakers Report 2 – Establishing an Election Committee  
27 13. Resolution 009 – Banning the Practice of Virginity Testing  
28

29 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 30  
31 14. Speakers Report 1 – Report of the Election Task Force  
32 15. Resolution 018 – Support for Safe and Equitable Access to Voting  
33 16. Resolution 019 - Disaggregation of Demographic Data for Individuals of Middle  
34 Eastern and North African (MENA) Descent

- 1 17. Resolution 020 – Recognizing and Remediating "Structural Urbanism" Bias as a  
2 Factor in Rural Health Disparities  
3 18. Resolution 023 - AMA Council on Ethical and Judicial Affairs (CEJA) report on  
4 Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2  
5

6 **RECOMMENDED FOR REFERRAL**  
7

- 8 19. Resolution 008 - Amendment to Truth and Transparency in Pregnancy  
9 Counseling Centers, H-420.954  
10

11 **RECOMMENDED FOR NOT ADOPTION**  
12

- 13 20. Resolution 002 - Disaggregation of Race Data for Individuals of Middle Eastern  
14 and North African (MENA) Descent  
15 21. Resolution 021 - Free Speech and Civil Discourse in the American Medical  
16 Association  
17 22. Resolution 022 - Prohibition of Racist Characterization Based on Personal  
18 Attributes

**Amendments**

If you wish to propose an amendment to an item of business, click here: [Submit New Amendment](#)

19

**RECOMMENDED FOR ADOPTION**

- 1  
2  
3 (1) BOARD OF TRUSTEES REPORT 5 – TERMS AND  
4 LANGUAGE IN POLICIES ADOPTED TO PROTECT  
5 POPULATIONS FROM DISCRIMINATION AND  
6 HARASSMENT

7  
8 **RECOMMENDATION:**

9  
10 **Recommendations in Board of Trustees Report 5 be**  
11 **adopted and the remainder of the Report be filed.**

12  
13 **HOD ACTION: Recommendations in Board of Trustees**  
14 **Report 5 adopted and the remainder of the Report filed.**

15  
16 The Board of Trustees recommends that Policy G-600.067, “Terms and Language in  
17 Policies Adopted to Protect Populations from Discrimination and Harassment,” be  
18 rescinded, the following be adopted, and the remainder of this report be filed:

- 19  
20 1. That our AMA recommend preferred terminology for protected personal characteristics  
21 to be used in AMA policies and position statements. (Directive to Take Action)

22  
23 Testimony was heard in general support of Board of Trustees Report 5. Testimony noted  
24 that the report aims to recommend consistency by optimizing language to protect  
25 vulnerable populations. Speakers noted that it is essential that the House of Medicine  
26 have a common definition of terms to prevent misunderstandings and facilitate  
27 collaboration to move medicine forward. One amendment suggested that the report be  
28 amended to replace “his/her” to “an individual’s” in policy H-140.837, however, this  
29 amendment was offered on existing policy cited in the body of the report and not within  
30 the recommendations themselves. Your Reference Committee recommends that the  
31 recommendations in Board of Trustees Report 5 be adopted and the remainder of the  
32 report be filed.

33  
34 Policy G-600.067, “Terms and Language in Policies Adopted to Protect  
35 Populations from Discrimination and Harassment”

36  
37 Our AMA will: (1) undertake a study to identify all discrimination and harassment  
38 references in AMA policies and the code of ethics, noting when the language is  
39 consistent and when it is not; (2) research language and terms used by other  
40 national organizations and the federal government in their policies on  
41 discrimination and harassment; (3) present the preliminary study results to the  
42 Minority Affairs Section, the Women’s Physician Section, and the Advisory  
43 Committee on LGBTQ Issues to reach consensus on optimal language to protect  
44 vulnerable populations including racial and ethnic minorities, sexual and gender  
45 minorities, and women, from discrimination and harassment; and (4) produce a  
46 report within 18 months with study results and recommendations.

1 (2) BOARD OF TRUSTEES REPORT 11 – NATIONAL  
2 GUIDELINES FOR GUARDIANSHIP  
3

4 **RECOMMENDATION:**  
5

6 **Recommendations in Board of Trustees Report 11 be**  
7 **adopted and the remainder of the Report be filed.**  
8

9 **HOD ACTION: Recommendations in Board of Trustees**  
10 **Report 11 adopted and the remainder of the Report filed.**  
11

12 The Board of Trustees recommends that the following be adopted in lieu of Resolution  
13 17-A-19, and the remainder of this report be filed:  
14

- 15 1. That Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse;" H-  
16 515.961, "Elder Mistreatment;" and H-515-984, "Health Care Costs of Violence and  
17 Abuse Across the Lifespan," be reaffirmed. (Reaffirm HOD Policy)  
18  
19 2. That our AMA support initiatives by the American Bar Association Commission on  
20 Law and Aging and other associations and agencies of the federal government to  
21 address elder abuse and to ensure consistent protection of elders' rights in all states.  
22 (Directive to Take Action)  
23

24 The report was introduced by the Board of Trustees, and no further testimony was heard.  
25 Your Reference Committee recommends that the recommendations in Board of Trustees  
26 Report 11 be adopted and the remainder of the report be filed.  
27

28 Ethical Opinion E-8.10, "Preventing, Identifying and Treating Violence and Abuse"  
29

30 All patients may be at risk for interpersonal violence and abuse, which may  
31 adversely affect their health or ability to adhere to medical recommendations. In  
32 light of their obligation to promote the well-being of patients, physicians have an  
33 ethical obligation to take appropriate action to avert the harms caused by violence  
34 and abuse.  
35

36 To protect patients' well-being, physicians individually should:  
37

- 38 (a) Become familiar with:  
39 i. how to detect violence or abuse, including cultural variations in  
40 response to abuse;  
41 ii. community and health resources available to abused or vulnerable  
42 persons;  
43 iii. public health measures that are effective in preventing violence  
44 and abuse;  
45 iv. legal requirements for reporting violence or abuse.  
46 (b) Consider abuse as a possible factor in the presentation of medical  
47 complaints.  
48 (c) Routinely inquire about physical, sexual, and psychological abuse as part  
49 of the medical history.

- 1 (d) Not allow diagnosis or treatment to be influenced by misconceptions about  
2 abuse, including beliefs that abuse is rare, does not occur in “normal”  
3 families, is a private matter best resolved without outside interference, or is  
4 caused by victims’ own actions.
- 5 (e) Treat the immediate symptoms and sequelae of violence and abuse and  
6 provide ongoing care for patients to address long-term consequences that  
7 may arise from being exposed to violence and abuse.
- 8 (f) Discuss any suspicion of abuse sensitively with the patient, whether or not  
9 reporting is legally mandated, and direct the patient to appropriate  
10 community resources.
- 11 (g) Report suspected violence and abuse in keeping with applicable  
12 requirements. Before doing so, physicians should:
  - 13 i. inform patients about requirements to report;
  - 14 ii. obtain the patient’s informed consent when reporting is not required  
15 by law. Exceptions can be made if a physician reasonably believes  
16 that a patient’s refusal to authorize reporting is coerced and  
17 therefore does not constitute a valid informed treatment decision.
- 18 (h) Protect patient privacy when reporting by disclosing only the minimum  
19 necessary information.

20  
21 Collectively, physicians should:

- 22
- 23 (i) Advocate for comprehensive training in matters pertaining to violence and  
24 abuse across the continuum of professional education.
- 25 (j) Provide leadership in raising awareness about the need to assess and  
26 identify signs of abuse, including advocating for guidelines and policies to  
27 reduce the volume of unidentified cases and help ensure that all patients  
28 are appropriately assessed.
- 29 (k) Advocate for mechanisms to direct physicians to community or private  
30 resources that might be available to aid their patients.
- 31 (l) Support research in the prevention of violence and abuse and collaborate  
32 with public health and community organizations to reduce violence and  
33 abuse.
- 34 (m) Advocate for change in mandatory reporting laws if evidence indicates that  
35 such reporting is not in the best interests of patients.

36  
37 Policy H-515.961, “Elder Mistreatment”

38  
39 Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public  
40 health problem that requires an organized effort from physicians and all medical  
41 professionals to improve the timely recognition and provision of clinical care in  
42 vulnerable elders who experience mistreatment; and (2) the importance of an  
43 interdisciplinary and collaborative approach to this issue, and encourage states to  
44 bring together teams with representatives from medicine, nursing, social work,  
45 adult protective services (APS), criminal and civil law, and law enforcement to  
46 develop appropriate interventions and evaluate their effectiveness.

1 Policy D-515.984, "Health Care Costs of Violence and Abuse Across the Lifespan"

2  
3 1. Our AMA urges the National Academies of Sciences, Engineering, and  
4 Medicine to continue to study the impact and health care costs of violence and  
5 abuse across the lifespan.

6  
7 2. Our AMA encourages the National Institutes of Health, the Agency for  
8 Healthcare Research and Quality, and the Centers for Disease Control and  
9 Prevention to conduct research on the cost savings resulting from health  
10 interventions on violence and abuse.

11  
12 3. Our AMA encourages the appropriate federal agencies to increase funding for  
13 research on the impact and health care costs of elder mistreatment.

14  
15 (3) BOARD OF TRUSTEES REPORT 13 – STUDY OF  
16 FORCED ORGAN HARVESTING BY CHINA

17  
18 **RECOMMENDATION:**

19  
20 **Recommendations in Board of Trustees Report 13 be**  
21 **adopted and the remainder of the Report be filed.**

22  
23 **HOD ACTION: Recommendations in Board of Trustees**  
24 **Report 13 adopted and the remainder of the Report filed.**

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

28  
29 1. That our American Medical Association continue to engage the Chinese Medical  
30 Association and the transplant community in the People's Republic of China (PRC)  
31 through promotion and support of relevant activities and policies of the World Medical  
32 Association that relate to organ transplantation. (Directive to Take Action)

33  
34 2. That our AMA, through its membership in the World Medical Association, continue to  
35 call for the PRC's compliance with internationally recognized organ transplantation  
36 standards, such as those of the World Health Organization, and for the PRC to make  
37 available externally verifiable data on organ transplantation. (Directive to Take Action)

38  
39 3. That our AMA condemn the retrieval of organs for transplantation without the informed  
40 consent of the donor. (New HOD Policy)

41  
42 4. That Policy D-370.981, "Study of Forced Organ Harvesting by China," be rescinded,  
43 having been accomplished by this report. (Rescind HOD Policy)

44  
45 Testimony was heard in unanimous support of Board of Trustees Report 13. Your  
46 Reference Committee recommends that the recommendations in Board of Trustees  
47 Report 13 be adopted and the remainder of the report be filed.

1 Policy D-370.981, "Study of Forced Organ Harvesting by China"  
2

3 Our AMA will gather and study all information available and possible on the issue  
4 of forced organ harvesting by China and issue a report to our House of Delegates  
5 at the 2020 Annual Meeting.  
6

- 7 (4) BOARD OF TRUSTEES REPORT 15 – OPPOSING  
8 ATTORNEY PRESENCE AT AND/OR RECORDING OF  
9 INDEPENDENT MEDICAL EXAMINATIONS

10  
11 **RECOMMENDATION:**  
12

13 **Recommendations in Board of Trustees Report 15 be**  
14 **adopted and the remainder of the report be filed.**

15  
16 **HOD ACTION: Recommendations in Board of Trustees**  
17 **Report 15 adopted and the remainder of the report filed.**  
18

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

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

28 Testimony was heard in general support of this report. Supporting testimony noted that  
29 the presence of recording devices or third parties may inhibit physicians' ability to receive  
30 the information they need from patients. Additional supporting testimony noted that given  
31 the variation in state laws regarding independent medical examinations and workers'  
32 compensation, a blanket policy opposing this in all instances is not practical, and it thus  
33 makes sense for the AMA to provide assistance and consultation on this matter at the  
34 request of state medical associations and national specialty societies. Opposing testimony  
35 noted that independent medical examinations are not truly independent, and recording  
36 should be encouraged for the protection of those making claims of injury or disability. Your  
37 Reference Committee believes that the recommendations given in this report are  
38 supported by the preponderance of testimony, and therefore recommends that the  
39 recommendations in Board of Trustees Report 15 be adopted and the remainder of the  
40 report be filed.  
41

- 42 (5) BOARD OF TRUSTEES REPORT 16 – RESEARCH  
43 HANDLING OF DE-IDENTIFIED PATIENT INFORMATION  
44

45 **RECOMMENDATION:**  
46

47 **Recommendations in Board of Trustees Report 16 be**  
48 **adopted and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Board of Trustees  
Report 16 adopted and the remainder of the report filed.**

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

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

2. That our AMA adopt a technical change to Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," by addition as follows: (Modify Current HOD Policy)

Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information"

Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

3. That our AMA support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. (New HOD Policy)

4. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data. (Directive to Take Action)

5. That Policy D-315.975, "Research Handling of De-Identified Patient Information," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

This report was introduced by the Board of Trustees and further testimony was minimal. An amendment was offered suggesting that additional language be added to specifically state that use and disclosure of patient information be consistent with federal, state, local, or tribal law, regulation, or policy, but your Reference Committee believes that these laws, regulations and policies will be considered regardless. Your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.



1 Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic  
2 Medical Record Information"

3  
4 Our AMA expressly advocates for physician ownership of all claims data,  
5 transactional data and de-identified aggregate data created, established and  
6 maintained by a physician practice, regardless of how and where such data is  
7 stored but specifically including any such data derived from a physician's medical  
8 records, electronic health records, or practice management system, while  
9 preserving the principle that physicians act as trusted stewards of Protected Health  
10 Information.

11  
12 Policy H-315.975, "Police, Payer, and Government Access to Patient Health  
13 Information"

14  
15 (1) Our AMA advocates vigorously, with respect to the final privacy rule or other  
16 privacy legislation, to define "health care operations" narrowly to include only those  
17 activities and functions that are routine and critical for general business operations  
18 and that cannot reasonably be undertaken with de-identified information.

19  
20 (2) Our AMA advocates vigorously, with respect to the final privacy rule or other  
21 privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and  
22 other payers shall have access to medical records and individually identifiable  
23 health information solely for billing and payment purposes, and routine and critical  
24 health care operations that cannot reasonably be undertaken with de-identified  
25 health information.

26  
27 (3) Our AMA advocates vigorously, with respect to the final privacy rule or other  
28 privacy legislation, that CMMS and other payers may access and use medical  
29 records and individually identifiable health information for non-billing, non-payment  
30 purposes and non-routine, non-critical health care operations that cannot  
31 reasonably be undertaken with de-identified health information, only with the  
32 express written consent of the patient or the patient's authorized representative,  
33 each and every time, separate and apart from blanket consent at time of  
34 enrollment.

35  
36 (4) Our AMA advocates vigorously, with respect to the final privacy rule or other  
37 privacy legislation that no government agency, including law enforcement  
38 agencies, be permitted access to medical records or individually identifiable health  
39 information (except for any discretionary or mandatory disclosures made by  
40 physicians and other health care providers pursuant to ethical guidelines or to  
41 comply with applicable state or federal reporting laws) without the express written  
42 consent of the patient, or a court order or warrant permitting such access.

43  
44 (5) Our AMA continues to strongly support and advocate a minimum necessary  
45 standard of disclosure of individually identifiable health information requested by  
46 payers, so that the information necessary to accomplish the intended purpose of  
47 the request be determined by physicians and other health care providers, as  
48 permitted under the final privacy rule.

1 Policy H-315.978, "Privacy and Confidentiality"

2  
3 Our AMA policy is that where possible, informed consent should be obtained  
4 before personally identifiable health information is used for any purpose. However,  
5 in those situations where specific informed consent is not practical or possible,  
6 either (1) the information should have identifying information stripped from it or (2)  
7 an objective, publicly accountable entity must determine that patient consent is not  
8 required after weighing the risks and benefits of the proposed use. Re-identification  
9 of personal health information should only occur with patient consent or with the  
10 approval of an objective, publicly accountable entity.

11  
12 Policy H-315.987, "Limiting Access to Medical Records"

13  
14 Our AMA: (1) will pursue the adoption of federal legislation and regulations that  
15 will: limit third party payers' random access to patient records unrelated to required  
16 quality assurance activities; limit third party payers' access to medical records to  
17 only that portion of the record (or only an abstract of the patient's records)  
18 necessary to evaluate for reimbursement purposes; require that requests for  
19 information and completion of forms be delineated and case specific; allow a  
20 summary of pertinent information relative to any inquiry into a patient's medical  
21 record be provided in lieu of a full copy of the records (except in instances of  
22 litigation where the records would be discoverable); and provide proper  
23 compensation for the time and skill spent by physicians and others in preparing  
24 and completing forms or summaries pertaining to patient records; and (2) supports  
25 the policy that copies of medical records of service no longer be required to be  
26 sent to insurance companies, Medicaid or Medicare with medical bills.

27  
28 Policy D-315.975, "Research Handling of De-Identified Patient Information"

29  
30 Our AMA will study the handling of de-identified patient information and report  
31 findings and recommendations back to the AMA House of Delegates.

32  
33 (6) BOARD OF TRUSTEES REPORT 20 - SPECIALTY  
34 SOCIETY REPRESENTATION IN THE HOUSE OF  
35 DELEGATES FIVE-YEAR REVIEW

36  
37 **RECOMMENDATION:**

38  
39 **Recommendations in Board of Trustees Report 20 be**  
40 **adopted and the remainder of the report be filed.**

41  
42 **HOD ACTION: Recommendations in Board of Trustees**  
43 **Report 20 adopted and the remainder of the report filed.**

44  
45 The Board of Trustees recommends that the following be adopted, and the remainder of  
46 this report be filed:

- 47  
48 1. That the American Academy of Insurance Medicine, American Academy of Sleep  
49 Medicine, American Society of Gastrointestinal Endoscopy, American Urological  
50 Association, American Society of Plastic Surgeons, AMSUS The Society of Federal

1 Health Professionals and North American Spine Society retain representation in  
2 the American Medical Association House of Delegates. (Directive to Take Action)

3  
4 2. Having failed to meet the requirements for continued representation in the AMA  
5 House of Delegates as set forth in AMA Bylaw B-8.5, American Society of  
6 Radiation Oncology, American Society for Surgery of the Hand, Society for  
7 Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic  
8 Surgeons be placed on probation and be given one year to work with AMA  
9 membership staff to increase their AMA membership. (Directive to Take Action)

10  
11 3. Having failed to meet the requirements for continued representation in the AMA  
12 House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to  
13 increase membership, the American Society of Abdominal Surgeons and the  
14 International Association of Independent Medical Evaluators not retain  
15 representation in the House of Delegates. (Directive to Take Action)

16  
17 This report was introduced by the Board of Trustees and limited supporting testimony was  
18 heard. Your Reference Committee recommends that the recommendations in Board of  
19 Trustees Report 20 be adopted and the remainder of the report be filed.

20  
21 (7) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1  
22 – FURTHER ACTION ON BYLAW 7.5.2

23  
24 **RECOMMENDATION:**

25  
26 **Recommendations in Council on Constitution and**  
27 **Bylaws Report 1 be adopted and the remainder of the**  
28 **report be filed.**

29  
30 **HOD ACTION: Recommendations in Council on**  
31 **Constitution and Bylaws Report 1 adopted and the**  
32 **remainder of the report filed.**

33  
34 The Council on Constitution and Bylaws recommends that the following amendments to  
35 the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption  
36 requires the affirmative vote of two-thirds of the members of the House of Delegates  
37 present and voting.

38  
39 7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

40  
41 7.5.1 Membership. All active physician members of the AMA who are not resident/fellow  
42 physicians, but who are under 40 years of age or are within the first 8 years of  
43 professional practice after residency and fellowship training programs, shall be members  
44 of the Young Physicians Section until December 31 of the year of their 40th birthday or  
45 December 31 of the eighth year following completion of their graduate medical  
46 education, whichever comes last.

47  
48 7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council  
49 member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the  
50 expiration of the term for which elected, the term of such member shall terminate and the

1 position shall be declared vacant. If any member's term would terminate prior to the  
2 conclusion of an Annual Meeting, such member shall be permitted to serve in office until  
3 the conclusion of the Annual Meeting ~~in the calendar year~~ following that when such  
4 member ceases to meet the membership requirements of Bylaw 7.5.1, as  
5 long as the member remains an active physician member of the AMA.  
6

7 7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-  
8 elect, chair, and immediate past chair. The young physician must meet the requirements  
9 of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The chair-elect, chair and  
10 immediate past chair shall be granted membership in the Section and be permitted to  
11 complete the term of office even if unable to continue to meet all of the requirements of  
12 Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.  
13

14 (Modify Bylaws)

15  
16 The report was introduced by the author, and limited supporting testimony was heard.  
17 Your Reference Committee recommends that the recommendations in Council on  
18 Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.  
19

- 20 (8) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2  
21 – RESCISSION OF BYLAWS RELATED TO RUN-OFF  
22 ELECTIONS  
23

24 **RECOMMENDATION:**

25  
26 **Recommendations in Council on Constitution and**  
27 **Bylaws Report 2 be adopted and the remainder of the**  
28 **report be filed.**  
29

30 **HOD ACTION: Recommendations in Council on**  
31 **Constitution and Bylaws Report 2 adopted and the**  
32 **remainder of the report filed.**  
33

34 The Council on Constitution and Bylaws recommends that the following amendments to  
35 the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption  
36 requires the affirmative vote of two-thirds of the members of the House of Delegates  
37 present and voting.  
38

39 3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall  
40 elect. All other elections shall be by ballot.  
41

42 \*\*\*  
43

44 ~~3.4.2.2 At Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The~~  
45 ~~nomination and election of Trustees to fill a vacancy that did not exist at the time of the~~  
46 ~~prior ballot shall be held after election of other Trustees and shall follow the same~~  
47 ~~procedure. Individuals so elected shall be elected to a complete 4 year term of office.~~  
48 ~~Unsuccessful candidates in any election for Trustee, other than the young physician~~  
49 ~~trustee and the resident/fellow physician trustee, shall automatically be nominated for~~

1 ~~subsequent elections until all Trustees have been elected. In addition, nominations from~~  
2 ~~the floor shall be accepted.~~

3  
4 [Subsequent bylaw provisions will be renumbered accordingly.]

5  
6 \*\*\*\*

7  
8 6.8 Election - Council on Constitution and Bylaws, Council on Medical Education,  
9 Council on Medical Service, and Council on Science and Public Health.

10  
11 \*\*\*

12  
13 ~~6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot. The~~  
14 ~~nomination and election of members of the Council to fill a vacancy that did not exist at~~  
15 ~~the time of the prior ballot shall be held after election of other members of the Council,~~  
16 ~~and shall follow the same procedure. Individuals elected to such vacancy shall be~~  
17 ~~elected to a complete 4-year term. Unsuccessful candidates in the election for members~~  
18 ~~of the Council shall automatically be nominated for subsequent elections to fill any such~~  
19 ~~vacancy until all members of the Council have been elected. In addition, nominations~~  
20 ~~from the floor shall be accepted.~~

21  
22 (Modify Bylaws)

23  
24 The report was introduced by the author and no further testimony was heard. Your  
25 Reference Committee recommends that the recommendations in Council on Constitution  
26 and Bylaws Report 2 be adopted and the remainder of the report be filed.

27  
28 (9) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 3  
29 – AMA WOMEN PHYSICIANS SECTION:  
30 CLARIFICATION OF BYLAW LANGUAGE

31  
32 **RECOMMENDATION:**

33  
34 **Recommendations in Council on Constitution and**  
35 **Bylaws Report 3 be adopted and the remainder of the**  
36 **report be filed.**

37  
38 **HOD ACTION: Recommendations in Council on**  
39 **Constitution and Bylaws Report 3 adopted and the**  
40 **remainder of the report filed.**

41  
42 The Council on Constitution and Bylaws recommends: 1) that the following amendments  
43 to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed.  
44 Adoption requires the affirmative vote of two-thirds of the members of the House of  
45 Delegates present and voting.

46  
47 7.10 Women Physicians Section. The Women Physicians Section is a delineated  
48 Section.  
49

1 7.10.1 Membership. All female physicians and female medical students who are active  
2 members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section.  
3 ~~7.10.1.4 Other active members of the AMA who express an interest in women's issues~~  
4 ~~may also shall be eligible to join the section. (Modify Bylaws)~~

5  
6 The report was introduced by the author, and limited supporting testimony was heard.  
7 Your Reference Committee recommends that the recommendations in Council on  
8 Constitution and Bylaws Report 3 be adopted and the remainder of the report be filed.

9  
10 (10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
11 REPORT 1 - SHORT-TERM MEDICAL SERVICE TRIPS

12  
13 **RECOMMENDATION:**

14  
15 **Recommendations in Council on Ethical and Judicial**  
16 **Affairs Report 1 be adopted and the remainder of the**  
17 **report be filed.**

18  
19 **HOD ACTION: Recommendations in Council on Ethical and**  
20 **Judicial Affairs Report 1 referred.**

21  
22 In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that  
23 the following be adopted and the remainder of this report be filed:

24  
25 Short-term medical service trips, which send physicians and physicians in training from  
26 wealthier countries to provide care in resource-limited settings for a period of days or  
27 weeks, have emerged as a prominent response for addressing global health inequities.  
28 They also provide training and educational opportunities, thus offering benefit both to the  
29 communities that host them and the medical professionals and trainees who volunteer  
30 their time and clinical skills.

31  
32 By definition, short-term medical service trips take place in contexts of scarce resources  
33 and in the shadow of colonial histories. These realities define fundamental ethical  
34 responsibilities to enable good health outcomes, promote justice and sustainability,  
35 minimize burdens on host communities, and respect persons and local cultures.  
36 Responsibly carrying out short-term medical service trips requires diligent preparation on  
37 the part of sponsors and participants in collaboration with host communities.  
38 Physicians and trainees who are involved with short-term medical service trips should  
39 ensure that the trips with which they are associated:

40  
41 (a) Focus prominently on promoting justice and sustainability by collaborating with the  
42 host community to define mission parameters, including identifying community needs,  
43 mission goals, and how the volunteer medical team will integrate with local health care  
44 professionals and the local health care system. In collaboration with the host community,  
45 short-term medical service trips should identify opportunities for and priority of efforts to  
46 support the community in building health care capacity. Trips that also serve secondary  
47 goals, such as providing educational opportunities for trainees, should prioritize benefits  
48 as defined by the host community over benefits to members of the volunteer medical team.

49

1 (b) Seek to proactively identify and minimize burdens the trip may place on the host  
2 community, including not only direct, material costs of hosting volunteers, but on possible  
3 disruptive effects the presence of volunteers could have for local practice and practitioners  
4 as well. Sponsors and participants should ensure that team members practice only within  
5 their skill sets and experience, and that resources are available to support the success of  
6 the trip, including arranging for local mentors, translation services, and volunteers'  
7 personal health needs as appropriate.  
8

9 (c) Seek to become broadly knowledgeable about the communities in which they will  
10 work and take advantage of resources to begin to cultivate the "cultural sensitivity" they  
11 will need to provide safe, respectful, patient-centered care in the context of the specific  
12 host community. Members of the volunteer medical team are expected to uphold the ethics  
13 standards of their profession and volunteers should insist that strategies are in place to  
14 address ethical dilemmas as they arise. In cases of irreducible conflict with local norms,  
15 volunteers may withdraw from care of an individual patient or from the mission after careful  
16 consideration of the effect that will have on the patient, the medical team, and the mission  
17 overall, in keeping with ethics guidance on the exercise of conscience.  
18

19 Sponsors of short-term medical service trips should:  
20

21 (d) Ensure that resources needed to meet the defined goals of the trip will be in place,  
22 particularly resources that cannot be assured locally.  
23

24 (e) Proactively define appropriate roles and permissible range of practice for members  
25 of the volunteer team, including the training, experience, and oversight of team members  
26 required to provide acceptable safe, high-quality care in the host setting. Team members  
27 should practice only within the limits of their training and skills in keeping with the  
28 professional standards of the sponsor's country.  
29

30 (f) Put in place a mechanism to collect data on success in meeting collaboratively  
31 defined goals for the trip in keeping with recognized standards for the conduct of health  
32 services research and quality improvement activities in the sponsor's country.  
33

34 (New HOD/CEJA Policy)  
35

36 Limited, mixed testimony was heard on this report. Testimony in favor of referral  
37 expressed concern that issues regarding scope of practice on medical service trips not  
38 exceeding the scope of the licensee in the practitioner's home state, working with local  
39 communities, supervising trainees, and potential harm caused by these trips were not  
40 adequately addressed in the recommendations. Another speaker expressed concern that  
41 sections (d) and (f) of the recommendations may be unrealistic. Testimony in favor of  
42 adoption lauded the improved recommendations in this report over the previous version,  
43 including support from those who organize medical service trips. Your Reference  
44 Committee believes that the issues of concern are adequately addressed in the  
45 recommendations, particularly in the first three points of guidance. Therefore, your  
46 Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1  
47 be adopted and the remainder of the report be filed.

- 1 (11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS  
2 REPORT 2 - AMENDMENTS TO OPINIONS 1.2.11,  
3 "ETHICAL INNOVATION IN MEDICAL PRACTICE";  
4 11.1.2, "PHYSICIAN STEWARDSHIP OF HEALTH CARE  
5 RESOURCES"; 11.2.1, "PROFESSIONALISM IN HEALTH  
6 CARE SYSTEMS"; AND 1.1.6, "QUALITY"  
7

8 **RECOMMENDATION:**

9  
10 **Recommendations in Council on Ethical and Judicial**  
11 **Affairs Report 2 be adopted and the remainder of the**  
12 **report be filed.**

13  
14 **HOD ACTION: Recommendations in Council on Ethical and**  
15 **Judicial Affairs Report 2 adopted and the remainder of the**  
16 **report filed.**  
17

18 In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that  
19 Opinion 1.2.11, "Ethically Sound Innovation in Medical Practice"; Opinion 11.2.1,  
20 "Professionalism in Health Care Systems"; Opinion 11.1.2, "Physician Stewardship of  
21 Health Care Resources"; and Opinion 1.1.6, "Quality," be amended as follows and the  
22 remainder of this report be filed:  
23

24 1. Opinion 1.2.11, Ethically Sound Innovation in Clinical Practice

25  
26 Innovation in medicine can span a wide range of activities. ~~From~~ It encompasses not  
27 only improving an existing intervention, ~~to introducing an innovation in one's own~~  
28 ~~clinical practice for the first time, to~~ using an existing intervention in a novel way, or  
29 translating knowledge from one clinical context into another but also developing or  
30 implementing new technologies to enhance diagnosis, treatment, and health care  
31 operations. Innovation shares features with both research and patient care, but it is  
32 distinct from both.  
33

34 When physicians participate in developing and disseminating innovative practices,  
35 they act in accord with professional responsibilities to advance medical knowledge,  
36 improve quality of care, and promote the well-being of individual patients and the  
37 larger community. Similarly, these responsibilities are honored when physicians  
38 enhance their own practices by expanding the range of tools, techniques, and or  
39 ~~interventions they offer to patients~~ employ in providing care.  
40

41 Individually, physicians who are involved in designing, developing, disseminating, or  
42 adopting innovative modalities should:  
43

- 44 (a) Innovate on the basis of sound scientific evidence and appropriate clinical  
45 expertise.  
46  
47 (b) Seek input from colleagues or other medical professionals in advance or as early  
48 as possible in the course of innovation.  
49



1 (c) Design innovations so as to minimize risks to individual patients and maximize  
2 the likelihood of application and benefit for populations of patients.

3  
4 (d) Be sensitive to the cost implications of innovation.

5  
6 (e) Be aware of influences that may drive the creation and adoption of innovative  
7 practices for reasons other than patient or public benefit.

8  
9 When they offer existing innovative diagnostic or therapeutic services to individual  
10 patients, physicians must:

11  
12 (f) Base recommendations on patients' medical needs.

13  
14 (g) Refrain from offering such services until they have acquired appropriate  
15 knowledge and skills.

16  
17 (h) Recognize that in this context informed decision making requires the physician to  
18 disclose:

19  
20 (i) how a recommended diagnostic or therapeutic service differs from the  
21 standard therapeutic approach if one exists;

22  
23 (ii) why the physician is recommending the innovative modality;

24  
25 (iii) what the known or anticipated risks, benefits, and burdens of the  
26 recommended therapy and alternatives are;

27  
28 (iv) what experience the professional community in general and the physician  
29 individually has had to date with the innovative therapy;

30  
31 (v) what conflicts of interest the physician may have with respect to the  
32 recommended therapy.

33  
34 (i) Discontinue any innovative therapies that are not benefiting the patient.

35  
36 (j) Be transparent and share findings from their use of innovative therapies with  
37 peers in some manner. To promote patient safety and quality, physicians should  
38 share both immediate or delayed positive and negative outcomes.

39  
40 To promote responsible innovation, health care institutions and the medical  
41 profession should:

42  
43 (k) Ensure that innovative practices or technologies that are made available to  
44 physicians meet the highest standards for scientifically sound design and clinical  
45 value.

46  
47 (kl) Require that physicians who adopt innovative treatment or diagnostic techniques  
48 innovations into their practice have appropriate relevant knowledge and skills.

49  
50 (lm) Provide meaningful professional oversight of innovation in patient care.

1  
2 (~~nn~~) Encourage physician-innovators to collect and share information about the  
3 resources needed to implement their ~~innovative therapies~~ innovations safely,  
4 effectively, and equitably.  
5

6 2. Opinion 11.2.1, Professionalism in Health Care Systems  
7

8 Containing costs, promoting high-quality care for all patients, and sustaining  
9 physician professionalism are important goals. Models for financing and organizing  
10 the delivery of health care services often aim to promote patient safety and to  
11 improve quality and efficiency. However, they can also pose ethical challenges for  
12 physicians that could undermine the trust essential to patient-physician relationships.  
13

14 Payment models and financial incentives can create conflicts of interest among  
15 patients, health care organizations, and physicians. They can encourage  
16 undertreatment and overtreatment, as well as dictate goals that are not individualized  
17 for the particular patient.  
18

19 Structures that influence where and by whom care is delivered—such as  
20 accountable care organizations, group practices, health maintenance organizations,  
21 and other entities that may emerge in the future—can affect patients' choices, the  
22 patient-physician relationship, and physicians' relationships with fellow health care  
23 professionals.  
24

25 Formularies, clinical practice guidelines, decision support tools that rely on  
26 augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision  
27 making, may impinge on physicians' exercise of professional judgment and ability to  
28 advocate effectively for their patients, depending on how they are designed and  
29 implemented.  
30

31 Physicians in leadership positions within health care organizations and the  
32 profession should ~~ensure that practices for financing and organizing the delivery of~~  
33 ~~care:~~  
34

35 (a) Ensure that decisions to implement practices or tools for organizing the delivery  
36 of care are transparent and reflect input from key stakeholders, including  
37 physicians and patients.  
38

39 (b) ~~Reflect input from key stakeholders, including physicians and patients.~~  
40

41 (eb) Recognize that over reliance on financial incentives or other tools to  
42 influence clinical decision making may undermine physician professionalism.  
43

44 (dc) Ensure ~~ethically acceptable incentives~~ that all such tools:  
45

46 (i) are designed in keeping with sound principles and solid scientific evidence.  
47

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

1  
2 b. Practice guidelines, formularies, and ~~other~~ similar tools should be based  
3 on best available evidence and developed in keeping with ethics  
4 guidance.

5  
6 c. Clinical prediction models, decision support tools, and similar tools such  
7 as those that rely on AI technology must rest on the highest-quality data  
8 and be independently validated in relevantly similar populations of  
9 patients and care settings.

10  
11 (ii) are implemented fairly and do not disadvantage identifiable populations of  
12 patients or physicians or exacerbate health care disparities;

13  
14 (iii) are implemented in conjunction with the infrastructure and resources needed  
15 to support high-value care and physician professionalism;

16  
17 (iv) mitigate possible conflicts between physicians' financial interests and patient  
18 interests by minimizing the financial impact of patient care decisions and the  
19 overall financial risk for individual physicians.

20  
21 (ed) Encourage, rather than discourage, physicians (and others) to:

22  
23 (i) provide care for patients with difficult to manage medical conditions;

24  
25 (ii) practice at their full capacity, but not beyond.

26  
27 (fe) Recognize physicians' primary obligation to their patients by enabling physicians  
28 to respond to the unique needs of individual patients and providing avenues for  
29 meaningful appeal and advocacy on behalf of patients.

30  
31 (gf) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely  
32 monitored to:

33  
34 (i) identify and address adverse consequences;

35  
36 (ii) identify and encourage dissemination of positive outcomes.

37  
38 All physicians should:

39  
40 (hg) Hold physician-leaders accountable to meeting conditions for  
41 professionalism in health care systems.

42  
43 (ih) Advocate for changes in ~~health care payment and delivery models~~ how the  
44 delivery of care is organized to promote access to high-quality care for all patients.

45  
46 3. Opinion 11.1.2, Physician Stewardship of Health Care Resources

47  
48 Physicians' primary ethical obligation is to promote the well-being of individual  
49 patients. Physicians also have a long-recognized obligation to patients in general to  
50 promote public health and access to care. This obligation requires physicians to be

1 prudent stewards of the shared societal resources with which they are entrusted.  
2 Managing health care resources responsibly for the benefit of all patients is  
3 compatible with physicians' primary obligation to serve the interests of individual  
4 patients.

5  
6 To fulfill their obligation to be prudent stewards of health care resources, physicians  
7 should:

- 8  
9 (a) Base recommendations and decisions on patients' medical needs.  
10  
11 (b) Use scientifically grounded evidence to inform professional decisions when  
12 available.  
13  
14 (c) Help patients articulate their health care goals and help patients and their  
15 families form realistic expectations about whether a particular intervention is  
16 likely to achieve those goals.  
17  
18 (d) Endorse recommendations that offer reasonable likelihood of achieving the  
19 patient's health care goals.  
20  
21 (e) Use technologies that have been demonstrated to meaningfully improve clinical  
22 outcomes to Choose the course of action that requires fewer resources when  
23 alternative courses of action offer similar likelihood and degree of anticipated  
24 benefit compared to anticipated harm for the individual patient but require  
25 different levels of resources.  
26  
27 (f) Be transparent about alternatives, including disclosing when resource constraints  
28 play a role in decision making.  
29  
30 (g) Participate in efforts to resolve persistent disagreement about whether a costly  
31 intervention is worthwhile, which may include consulting other physicians, an  
32 ethics committee, or other appropriate resource.

33  
34 Physicians are in a unique position to affect health care spending. But individual  
35 physicians alone cannot and should not be expected to address the systemic  
36 challenges of wisely managing health care resources. Medicine as a profession must  
37 create conditions for practice that make it feasible for individual physicians to be  
38 prudent stewards by:

- 39  
40 (h) Encouraging health care administrators and organizations to make cost data  
41 transparent (including cost accounting methodologies) so that physicians can  
42 exercise well-informed stewardship.  
43  
44 (i) Advocating that health care organizations make available well-validated  
45 technologies to enhance diagnosis, treatment planning, and prognosis and  
46 support equitable, prudent use of health care resources.  
47  
48 (ij) Ensuring that physicians have the training they need to be informed about health  
49 care costs and how their decisions affect resource utilization and overall health  
50 care spending.

1  
2 (j) Advocating for policy changes, such as medical liability reform, that promote  
3 professional judgment and address systemic barriers that impede responsible  
4 stewardship.

5  
6 4. Opinion 1.1.6, Quality

7  
8 As professionals dedicated to promoting the well-being of patients, physicians  
9 individually and collectively share the obligation to ensure that the care patients  
10 receive is safe, effective, patient centered, timely, efficient, and equitable.

11  
12 While responsibility for quality of care does not rest solely with physicians, their role  
13 is essential. Individually and collectively, physicians should actively engage in efforts  
14 to improve the quality of health care by:

15  
16 (a) Keeping current with best care practices and maintaining professional  
17 competence.

18  
19 (b) Holding themselves accountable to patients, families, and fellow health care  
20 professionals for communicating effectively and coordinating care appropriately.

21  
22 (c) Using new technologies and innovations that have been demonstrated to  
23 improve patient outcomes and experience of care, in keeping with ethics  
24 guidance on innovation in clinical practice and stewardship of health care  
25 resources.

26  
27 (ed) Monitoring the quality of care they deliver as individual practitioners—e.g.,  
28 through personal case review and critical self-reflection, peer review, and use of  
29 other quality improvement tools.

30  
31 (Modify HOD/CEJA policy)

32  
33 Limited testimony was heard that generally supported Council on Ethical and Judicial  
34 Affairs Report 2, acknowledging the timeliness of this issue in providing guidance to  
35 individual physicians and institutions alike. One speaker who supported the report  
36 reminded physicians that implicit bias exists in certain algorithms, and that it is essential  
37 to keep this in mind when considering the use of emerging technologies. Speakers  
38 suggested adding clarifying language with regard to “augmented intelligence” and  
39 “artificial intelligence,” and suggested avoiding referring to augmented intelligence as “AI”  
40 to prevent confusion. However, your Reference Committee notes that our American  
41 Medical Association has adopted the use of the term “augmented intelligence”. Testimony  
42 was also offered that seems to transfer accountability of patient needs away from the  
43 physician and to the health care organization. Your Reference Committee believes that  
44 this is appropriate, given the employed status of many physicians which necessitates them  
45 using technologies adopted by their institutions. Your Reference Committee recommends  
46 that Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the  
47 report be filed.

1 (12) SPEAKERS REPORT 2 - ESTABLISHING AN ELECTION  
2 COMMITTEE

3  
4 **RECOMMENDATION:**

5  
6 **Recommendations in Speakers Report 2 be adopted**  
7 **and the remainder of the report be filed.**

8  
9 **HOD ACTION: Recommendations in Speakers Report 2**  
10 **referred for decision.**

11  
12 It is recommended that the following recommendations be adopted and the remainder of  
13 the report be filed.

14  
15 1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be  
16 established as follows:

17  
18 Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or  
19 the AMA General Counsel and should include the following details:

- 20  
21
- 22 • The name of the person(s) thought to have violated the rules
  - 23 • The date of the alleged violation and the location if relevant
  - 24 • The specific violation being alleged (i.e., the way the rules were violated)
  - 25 • The materials, if any, that violate the rules; original materials are preferred over  
26 copies.

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

28  
29 Campaign violation complaints will be investigated by the Election Committee, which will  
30 determine penalties for validated complaints as appropriate. Penalties may include an  
31 announcement of the violation by the Speaker to the House. (New HOD Policy)

32  
33 2. The Election Committee will review the Campaign Complaint Reporting, Validation,  
34 and Resolution Process as implemented and make further recommendations to the  
35 House as necessary. (Directive to Take Action)

36  
37 3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy)

38  
39 Your Reference Committee heard testimony that generally supported this report.  
40 Speakers suggested that any validated election violations that may occur should be  
41 delineated and reported, and that the potential exists for misunderstandings, false  
42 accusations and accusations not made in good faith. In response, an amendment was  
43 offered suggesting the inclusion of the language "in accordance with due process".  
44 However, this term can be confused with legal due process. Your Reference Committee  
45 believes that the language of the report is acceptable as written, and existing mechanisms  
46 exist to report violations. Your Reference Committee recommends that the  
47 recommendations in Speakers Report 2 be adopted and the remainder of the report be  
48 filed.

1 Policy D-610.998, "Directives from the Election Task Force"

2  
3 Campaign Receptions

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

13  
14 Campaign literature

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

19  
20 Interviews

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

23  
24 Voting Process and Election Session

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

30  
31 Election Committee

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

42  
43 6. The Speaker in consultation with the Election Committee will consider a more  
44 defined process for complaint reporting, validation, resolution, and potential  
45 penalties This process will be presented to the House for approval.

46  
47 Review of Implementation

48 7. After an interval of 2 years a review of our election process, including the  
49 adopted Recommendations from this report, be conducted by the Speaker and, at

1 the Speaker's discretion the appointment of another election task force, with a  
2 report back to the House.

3  
4 (13) RESOLUTION 009 – BANNING THE PRACTICE OF  
5 VIRGINITY TESTING

6  
7 **RECOMMENDATION:**

8  
9 **Resolution 009 be adopted.**

10  
11 **HOD ACTION: Resolution 009 adopted.**

12  
13 RESOLVED, That our American Medical Association advocate for the elimination of the  
14 practice of virginity testing exams, physical exams purported to assess virginity  
15 (Directive to Take Action); and be it further

16  
17 RESOLVED, That our AMA support culturally-sensitive counseling by health  
18 professionals to educate patients and family members about the negative effects and  
19 inaccuracy of virginity testing and where needed, referral for further psychosocial  
20 support (New HOD Policy); and be it further

21  
22 RESOLVED, That our AMA support efforts to educate medical students and physicians  
23 about the continued existence of the practice of virginity testing and its detrimental  
24 effects on patients. (New HOD Policy)

25  
26 Testimony was heard in strong support of Resolution 009. Speakers noted the timeliness  
27 of the resolution, as the topic has been part of recent national conversation. Speakers  
28 noted that virginity is not a scientific or medical term, and the practice of virginity testing is  
29 not evidence-based nor does it exist in medical literature. Further, speakers noted that the  
30 practice is unreliable, intrusive, harmful and is often performed without consent. Your  
31 Reference Committee recommends that Resolution 009 be adopted.



**RECOMMENDED FOR ADOPTION AS AMENDED**

(14) **SPEAKERS REPORT 1 - REPORT OF THE ELECTION  
TASK FORCE**

**RECOMMENDATION A:**

**Paragraph 12(e)(ii) be amended by addition and deletion to read as follows:**

**ii. It is encouraged that interviews be conducted on weeknights ~~must be scheduled~~ between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.**

**RECOMMENDATION B:**

**Recommendations in Speakers Report 1 be adopted as amended and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Speakers Report 1 adopted as amended and the remainder of the report filed.**

**(12) Interviews conducted with current candidates must comply with the following rules:**

- a. **Interviews may be arranged between the parties once active campaigning is allowed.**
- b. **Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.**
  - i. **A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.**
  - ii. **Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.**
  - iii. **Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.**
- c. **Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office**

- 1 ~~must be conducted using the same format and~~  
2 ~~platform.~~
- 3 d. In-person interviews may be conducted between  
4 Friday and Monday of the meeting at which  
5 elections will take place.
- 6 e. Virtual interviews are subject to the following  
7 constraints:
- 8 i. Interviews may be conducted only during a  
9 window beginning on the ~~Thursday Friday~~  
10 evening two ~~weekends~~ prior to the scheduled  
11 Opening Session of the House of Delegates  
12 meeting at which elections will take place and  
13 must be concluded by ~~that~~ Sunday (four days  
14 later) ~~evening one week before the scheduled~~  
15 Opening Session of the House.
- 16 ii. Interviews conducted on weeknights must be  
17 scheduled between 5 pm and 10 pm or on  
18 weekends between 8 am and 10 pm based on  
19 the candidate's local time, unless another  
20 mutually acceptable time outside these hours is  
21 arranged.
- 22 iii. Caucuses and delegations scheduling  
23 interviews for candidates within the parameters  
24 above ~~are not obligated to~~ must offer  
25 alternatives to those candidates who have  
26 conflicts with the scheduled time ~~but are~~  
27 encouraged to do so if possible.
- 28

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

34

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

45

46 ...

47

48 (11) The Speaker's Office will coordinate the scheduling of candidate interviews 1 for  
49 general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups  
50 wishing to conduct interviews must designate their interviewing coordinator and provide

1 the individual's contact information to the Office of House of Delegates Affairs. The  
2 Speaker's Office will collect contact information for groups wishing to conduct interviews  
3 as well as for candidates and their campaign teams and will provide the information as  
4 requested.

5  
6 (12) Interviews conducted with current candidates must comply with the following rules:

7  
8 a. Interviews may be arranged between the parties once active campaigning is allowed.

9  
10 b. Groups conducting interviews with candidates for a given office must offer an  
11 interview to all individuals that have officially announced their candidacy at the time the  
12 group's interview schedule is finalized.

13  
14 i. A group may meet with a candidate who is a member of their group without  
15 interviewing other candidates for the same office.

16  
17 ii. Interviewing groups may, but are not required to, interview late announcing  
18 candidates. Should an interview be offered to a late candidate, all other  
19 announced candidates for the same office (even those previously interviewed)  
20 must be afforded the same opportunity.

21  
22 iii. Any appearance by a candidate before an organized meeting of a caucus or  
23 delegation, other than their own, will be considered an interview and fall under  
24 the rules for interviews.

25  
26 c. Groups may elect to conduct interviews virtually or in-person, but not both. All  
27 interviews for an office must be conducted using the same format and platform.

28  
29 d. In-person interviews may be conducted between Friday and Monday of the meeting at  
30 which elections will take place.

31  
32 e. Virtual interviews are subject to the following constraints:

33  
34 i. Interviews may be conducted only during a window beginning on the Friday  
35 evening two weekends prior to the scheduled Opening Session of the House of  
36 Delegates meeting at which elections will take place and must be concluded by  
37 the Sunday evening one week before the scheduled Opening Session of the  
38 House.

39  
40 ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10  
41 pm or on weekends between 8 am and 10 pm based on the candidate's local  
42 time, unless another mutually acceptable time outside these hours is arranged.

43  
44 iii. Caucuses and delegations scheduling interviews for candidates within the  
45 parameters above are not obligated to offer alternatives but are encouraged to  
46 do so if possible.

47  
48 f. Recording of interviews is allowed only with the knowledge and consent of the  
49 candidate.

50

1 g. Recordings of interviews may be shared only among members of the group  
2 conducting the interview.

3  
4 h. A candidate is free to decline any interview request.

5  
6 i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a  
7 contested election, the Vice Speaker, may issue special rules for interviews to address  
8 unexpected situations.

9  
10 Testimony unanimously supported the intentions of Speakers Report 1. There were  
11 concerns, however, that the timing delineated in (e) did not work for individuals who work  
12 overnight shifts, third shifts, or who have family and other obligations. Several  
13 amendments were offered to address this, including to begin the interview window one  
14 weekend prior to the scheduled opening session of the House of Delegates rather than  
15 two, and to conclude the interview window by the opening session of the HOD, rather than  
16 the Sunday evening one weekend before. Others suggested removing defined times  
17 during which interviews should be scheduled to minimize conflict with candidate's working  
18 hours and to allow interviews during times mutually acceptable by the interviewers and  
19 interviewee. The sentiment of these amendments was supported, but others noted that  
20 the interviewers' schedules would be burdened by a lack of defined interview windows.  
21 The authors of the report noted that the proposed changes to the interview window had  
22 been considered, and that the times ultimately selected and delineated in the report were  
23 the result of extensive testimony from the HOD during discussion at the June 2021 Special  
24 Meeting. Your Reference Committee believes that the language suggested in the above  
25 amendment, which *encourages* interviews to take place during the stated times,  
26 sufficiently names the guardrail times without being overly proscriptive, still allows for a  
27 mutually acceptable alternate time to interview, and thus respects both the interviewer and  
28 interviewee's schedules. Your Reference Committee recommends that Speakers Report  
29 1 be adopted as amended and the remainder of the report be filed.

30  
31 (15) RESOLUTION 018 – SUPPORT FOR SAFE AND  
32 EQUITABLE ACCESS TO VOTING

33  
34 **RECOMMENDATION A:**

35  
36 **The first Resolve in Resolution 018 be amended by**  
37 **addition to read as follows:**

38  
39 **(g) use of a P.O. box for voter registration (New HOD**  
40 **Policy):**

41  
42 **RECOMMENDATION B:**

43  
44 **Resolution 018 be adopted as amended.**

45  
46 **HOD ACTION: Resolution 018 adopted as amended.**

47  
48 **RESOLVED**, That our AMA support measures to facilitate safe and equitable access to  
49 voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary  
50 risk of infectious disease transmission by measures including but not limited to:

- 1
- 2 (a) extending polling hours;
- 3 (b) increasing the number of polling locations;
- 4 (c) extending early voting periods;
- 5 (d) mail-in ballot postage that is free or prepaid by the government;
- 6 (e) adequate resourcing of the United States Postal Service and election
- 7 operational procedures;
- 8 (f) improve access to drop off locations for mail-in or early ballots (New HOD
- 9 Policy); and be it further

10  
11 RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order  
12 to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New  
13 HOD Policy)

14  
15 Testimony was heard in general support of this resolution. While most speakers noted  
16 their support for the intent of the resolution, several speakers noted that the process of  
17 voting in the United States is decentralized, with voting procedures largely determined by  
18 the states. Speakers in support noted that the COVID-19 pandemic has highlighted the  
19 issues with current voting infrastructure, and the resolution represents both a harm  
20 reduction strategy and a measure to improve equity for those for whom voting is difficult.  
21 An amendment was offered to add another provision to the resolution allowing for use of  
22 a P.O. box for voter registration to address individuals with nontraditional addresses or  
23 non-numbered addresses (such as on American Indian or Alaska Native reservations and  
24 in rural areas) and subsequent testimony was supportive. Your Reference Committee  
25 recommends that Resolution 018 be adopted as amended.

- 26  
27 (16) RESOLUTION 019 – DISAGGREGATION OF  
28 DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE  
29 EASTERN AND NORTH AFRICAN (MENA) DESCENT

30  
31 **RECOMMENDATION A:**

32  
33 **Resolution 019 be amended by addition of a third**  
34 **Resolve to read as follows:**

35  
36 **RESOLVED, that our AMA study methods to further**  
37 **improve disaggregation of data by race which most**  
38 **accurately represent the diversity of our patients.**

39  
40 **RECOMMENDATION B:**

41  
42 **Resolution 019 be adopted as amended.**

43  
44 **HOD ACTION: Resolution 019 adopted as amended.**

45  
46 RESOLVED, That our American Medical Association add “Middle Eastern/North African  
47 (MENA)” as a separate racial category on all AMA demographics forms (Directive to  
48 Take Action); and be it further

49

1 RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African  
2 (MENA)” as a separate race category in all uses of demographic data including but not  
3 limited to medical records, government data collection and research, and within medical  
4 education. (Directive to Take Action)  
5

6 Your Reference Committee heard testimony in strong support of Resolution 019.  
7 Speakers suggested that the resolution is important for accurate data collection, and that  
8 much of our misunderstanding of health disparities is the result of grouping individuals into  
9 broad race categories. It was also noted that while the economic impact of this resolution  
10 on the AMA is minimal, the social impact of no longer classifying those of Middle  
11 Eastern/North African (MENA) descent as “white” or “other” is significant. Limited  
12 testimony in opposition suggested that a standard definition of MENA does not currently  
13 exist and needs to be established, and an amendment was offered suggesting that the  
14 AMA “define and” add MENA as a separate racial category. Subsequent testimony  
15 insisted that further study was unnecessary given that definitions not only exist, but this  
16 data is self-reported. Finally, your Reference Committee agreed with the addition of a third  
17 resolve asking for study of methods to further improve disaggregation of data in general.  
18 Your Reference Committee recommends that Resolution 019 be adopted as amended.  
19

20 (17) RESOLUTION 020 – RECOGNIZING AND REMEDYING  
21 “STRUCTURAL URBANISM” BIAS AS A FACTOR IN  
22 RURAL HEALTH DISPARITIES  
23

24 **RECOMMENDATION A:**

25  
26 **The first Resolve in Resolution 020 be amended by**  
27 **deletion to read as follows:**  
28

29 **RESOLVED: that our AMA 1) formally recognize that**  
30 **systemic bias in healthcare financing {called**  
31 **“Structural Urbanism”}, has been one of many a factors**  
32 **in leading to rural health disparities, 2) and advocate for**  
33 **elimination of these biases through payment policy**  
34 **reform in future AMA strategic planning to reduce all of**  
35 **America’s health disparities, include plans to**  
36 **reduce/remedy the {structural urbanism} bias 3) in**  
37 **advocating for health equity for all Americans, point out**  
38 **that Medicare payment policies have played a role in to**  
39 **help reduce the shortage of rural physicians and**  
40 **eliminate the poorer health inequities outcomes in rural**  
41 **America (Directive to Take Action); and be it further**  
42

43 **RECOMMENDATION B:**

44  
45 **Resolution 020 be adopted as amended.**  
46

47 **RECOMMENDATION D:**

48  
49 **The title of Resolution 020 be changed to:**

1           **Recognizing and Remediating Payment System Bias As**  
2           **a Factor in Rural Health Disparities**

3  
4           **HOD ACTION: Resolution 020 adopted as amended with a**  
5           **change in title to read as follows:**

6  
7           **Recognizing and Remediating Payment System Bias As a**  
8           **Factor in Rural Health Disparities**

9  
10          RESOLVED, That our American Medical Association: (1) formally recognize that  
11          systemic bias in healthcare financing, called “Structural Urbanism,” has been a factor in  
12          leading to rural health disparities; (2) in future AMA strategic planning to reduce all of  
13          America’s health disparities, include plans to reduce/remedy the structural urbanism  
14          bias; and (3) point out, in advocating for health equity for all Americans, that Medicare  
15          payment policies have played a role in the shortage of rural physicians and the poorer  
16          health outcomes in rural America (Directive to Take Action); and be it further

17  
18          RESOLVED, That our AMA, as part of our current advocacy for telehealth reform,  
19          specify that geographic payment equity be required in any telehealth legislation.  
20          (Directive to Take Action)

21  
22          Your Reference Committee heard testimony in unanimous support of Resolution 020.  
23          Speakers noted two main issues: the long standing rural/urban health care financing  
24          disparity, and that persons who live in rural areas have been shown in research to have  
25          considerable health inequities. The authors submitted amended language to make these  
26          points clearer, and to avoid any confusion regarding the term “structural urbanism”.  
27          Subsequent testimony supported those proposed resolutions. Your Reference Committee  
28          recommends that Resolution 020 be adopted as amended.

29  
30          (18)    RESOLUTION 023 – AMA COUNCIL ON ETHICAL AND  
31                  JUDICIAL AFFAIRS (CEJA) REPORT ON PHYSICIAN  
32                  RESPONSIBILITIES TO IMPAIRED COLLEAGUES: CEJA  
33                  E-9.3.2

34  
35                  **RECOMMENDATION A:**

36  
37                  **The first Resolve of Resolution 023 be amended by**  
38                  **addition and deletion to read as follows:**

39  
40                  **Resolved, that our AMA advocate that health system,**  
41                  **corporate, and academic organizations provide for fair,**  
42                  **objective, and external ~~and independent review~~**  
43                  **evaluations review for physicians who are requested**  
44                  **or required to be assessed for a ~~potential impairment~~**  
45                  **potentially impairing health condition, and that such**  
46                  **evaluations are independent of conflicts of interest by**  
47                  **the examining and entity, and be it further**

48  
49                  **RECOMMENDATION B:**  
50

1           **The second Resolve of Resolution 023 be amended by**  
2           **addition and deletion to read as follows:**

3  
4           **Resolved, that our AMA support the availability of**  
5           **Pphysician Hhealth Pprograms to enable physicians**  
6           **who require assistance to receive provide safe and**  
7           **effective care; and be it further for physicians who are**  
8           **requested to be assessed for a potential impairment;**  
9           **and be it further**

10  
11           **RECOMMENDATION C:**

12  
13           **Resolution 023 be amended by addition of a third**  
14           **Resolve to read as follows:**

15  
16           **Resolved, that our AMA support that any clinical**  
17           **evaluation of a physician-in-training that is required by**  
18           **their academic institution regarding a potentially**  
19           **impairing health condition, be fair, objective, free of**  
20           **conflicts, and external to said trainee’s own academic**  
21           **institution or location where they may be placed for**  
22           **clinical rotations, and be it further**

23  
24           **RECOMMENDATION D:**

25  
26           **The final Resolve of Resolution 023 be amended by**  
27           **addition and deletion to read as follows:**

28  
29           **RESOLVED, That the Council on Ethical and Judicial**  
30           **Affairs consider the following amendment to Opinion E-**  
31           **9.3.2, “Physician Responsibilities to Colleagues with**  
32           **Illness, Disability or Impairment”:**

33  
34           **(i) Advocating for supportive services including**  
35           **physician health programs and accommodations to**  
36           **enable physicians and physicians in training who**  
37           **require assistance to provide safe, effective care.**

38  
39           **...**

40  
41           **(k) Advocating for fair, objective, external, and**  
42           **independent review evaluations for physicians when a**  
43           **review is requested or required to assess a potential**  
44           **impairment and its duration by an employer, academic**  
45           **medical center, or hospital/health system where said**  
46           **physician has clinical privileges or where said**  
47           **physician-in training is placed for a clinical rotations.**



1           **RECOMMENDATION E:**

2  
3           **Resolution 023 be adopted as amended.**

4  
5           **HOD ACTION: Resolution 023 adopted as amended.**

6  
7           **Resolved, that our AMA advocate that health system,**  
8           **corporate, and academic organizations provide for fair,**  
9           **objective, and external and independent review**  
10           **evaluations ~~review~~ for physicians who are requested**  
11           **or required to be assessed for a potential impairment**  
12           **potentially impairing due to a health condition, and**  
13           **that such evaluations are independent of conflicts of**  
14           **interest by the examining and entity, and be it further**

15  
16           **Resolved, that our AMA support the availability of**  
17           **P~~h~~physician H~~e~~alth P~~r~~ograms to enable physicians**  
18           **who require assistance to receive provide safe and**  
19           **effective care; and be it further for physicians who are**  
20           **requested to be assessed for a potential impairment;**  
21           **and be it further**

22  
23           **Resolved, that our AMA support that any clinical**  
24           **evaluation of a physician-in-training that is required by**  
25           **their academic institution regarding a potential**  
26           **impairment ~~potentially impairing due to a health~~**  
27           **condition, be fair, objective, free of conflicts, and**  
28           **external to said trainee's own academic institution or**  
29           **location where they may be placed for clinical**  
30           **rotations, and be it further**

31  
32           **RESOLVED, That the Council on Ethical and Judicial**  
33           **Affairs consider the following amendment to Opinion**  
34           **E-9.3.2, "Physician Responsibilities to Colleagues with**  
35           **Illness, Disability or Impairment":**

36  
37           **(i) Advocating for supportive services including**  
38           **physician health programs and accommodations to**  
39           **enable physicians and physicians in training who**  
40           **require assistance to provide safe, effective care.**

41  
42           **...**

43  
44           **(l) Advocating for fair, objective, external, and**  
45           **independent review evaluations for physicians when a**  
46           **review is requested or required to assess a potential**  
47           **impairment and its duration by an employer, academic**  
48           **medical center, or hospital/health system where said**  
49           **physician has clinical privileges or where said**  
50           **physician-in training is placed for a clinical rotations.**

1 RESOLVED, That our American Medical Association support a fair, objective, external  
2 and independent review for physicians who are requested to be assessed for a potential  
3 impairment, and support the availability of physician health programs to enable  
4 physicians who require assistance to provide safe and effective care (New HOD Policy);  
5 and be it further

6  
7 RESOLVED, That our AMA advocate that health system, corporate, and academic  
8 organizations provide a fair, objective, external and independent review for physicians  
9 who are requested to be assessed for a potential impairment (Directive to Take Action);  
10 and be it further

11  
12 RESOLVED, That the Council on Ethical and Judicial Affairs consider the following  
13 amendment to Opinion E-9.3.2, “Physician Responsibilities to Colleagues with Illness,  
14 Disability or Impairment”:

15  
16 (i) Advocating for supportive services including physician health programs and  
17 accommodations to enable physicians who require assistance to provide safe, effective  
18 care.

19 ...

20 (k) Advocating for fair, objective, external, and independent review for physicians when a  
21 review is requested to assess a potential impairment and its duration.

22  
23 Testimony was in favor of this resolution. Those who testified mentioned the importance  
24 of a fair, objective and independent review of physicians who require assessment for  
25 potential impairments. Several amendments were proffered on the online forum and  
26 received widespread support in the hearing. Further, there was support for including  
27 physicians-in-training, which is reflected in the added resolve. Lastly, several people  
28 testified that they would like the Council on Ethical and Judicial Affairs to consider including  
29 physician health programs specifically in Opinion 9.3.2 “Physician Responsibilities to  
30 Colleagues with Illness, Disability or Impairment”, as well as guidance regarding  
31 advocating for the fair, objective and independent reviews mentioned in the earlier  
32 resolves. Your Reference Committee recommends that Resolution 023 be adopted as  
33 amended.

34  
35 Ethical Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues”

36  
37 Physical or mental health conditions that interfere with a physician’s ability to  
38 engage safely in professional activities can put patients at risk, compromise  
39 professional relationships, and undermine trust in medicine. While protecting  
40 patients’ well-being must always be the primary consideration, physicians who are  
41 impaired are deserving of thoughtful, compassionate care.

42  
43 To protect patient interests and ensure that their colleagues receive appropriate  
44 care and assistance, individually physicians have an ethical obligation to:

- 45  
46 (a) Intervene in a timely manner to ensure that impaired colleagues cease  
47 practicing and receive appropriate assistance from a physician health  
48 program.

1 (b) Report impaired colleagues in keeping with ethics guidance and applicable  
2 law.

3  
4 (c) Assist recovered colleagues when they resume patient care.  
5

6 Collectively, physicians have an obligation to ensure that their colleagues are able  
7 to provide safe and effective care. This obligation is discharged by:  
8

9 (d) Promoting health and wellness among physicians.

10  
11 (e) Establishing mechanisms to assure that impaired physicians promptly  
12 cease practice.

13  
14 (f) Supporting peers in identifying physicians in need of help.

15  
16 (g) Establishing or supporting physician health programs that provide a  
17 supportive environment to maintain and restore health and wellness.

**RECOMMENDED FOR REFERRAL**

(19) RESOLUTION 008 – AMENDMENT TO TRUTH AND  
TRANSPARENCY IN PREGNANCY COUNSELING  
CENTERS, H-420.954

**RECOMMENDATION:**

**Resolution 008 be referred.**

**HOD ACTION: Resolution 008 referred.**

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

Truth and Transparency in Pregnancy Counseling Centers H-420.954

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

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

3. 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, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;

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

Testimony was heard in general support of the goals of the resolution, but a number of speakers expressed concern with the specific amendments in this resolution as written. Amendments were offered suggesting the removal of the term “marketing” in the proposed added part 2 of H-420.954 and removing the amendment by addition in part 3, with the speaker noting that it could not be monitored or enforced. Other amendments were proposed with the goal of preserving the intent of the resolution while mitigating unintended consequences. However, your Reference Committee heard compelling testimony that described the predatory actions by non-clinical pregnancy counseling

1 centers, and given the complexity of jurisdiction and enforcement, your Reference  
2 Committee believes that a report examining these issues is the best approach for our AMA  
3 to make an impact. Your Reference Committee recommends that Resolution 008 be  
4 referred.

5  
6 Policy H-420.954, "Truth and Transparency in Pregnancy Counseling Centers"

7  
8 1. Our AMA supports that any entity offering crisis pregnancy services disclose  
9 information on site, in its advertising, and before any services are provided  
10 concerning the medical services, contraception, termination of pregnancy or  
11 referral for such services, adoption options or referral for such services that it  
12 provides; and be it further

13  
14 2. Our AMA advocates that any entity providing medical or health services to  
15 pregnant women that markets medical or any clinical services abide by licensing  
16 requirements and have the appropriate qualified licensed personnel to do so and  
17 abide by federal health information privacy laws.

**RECOMMENDED FOR NOT ADOPTION**

- 1  
2  
3 (20) RESOLUTION 002 – DISAGGREGATION OF RACE  
4 DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND  
5 NORTH AFRICAN (MENA) DESCENT  
6

7 **RECOMMENDATION:**

8  
9 **Resolution 002 be not adopted.**

10  
11 **HOD ACTION: Resolution 002 not adopted.**

12  
13 RESOLVED, That our American Medical Association add “Middle Eastern/North African  
14 (MENA)” as a separate race category on all AMA demographics forms (Directive to Take  
15 Action); and be it further

16  
17 RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of  
18 “Middle Eastern/North African (MENA)” as a separate race category on all surveys  
19 conducted by the U.S. Census Bureau, and for all federally funded research using race  
20 categories (Directive to Take Action); and be it further

21  
22 RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of  
23 “Middle Eastern/North African (MENA)” as a separate race category on all medical  
24 school and residency demographics forms. (Directive to Take Action)

25  
26 Testimony for Resolution 002 was in strong support of the need of MENA as separate  
27 race category on both medical and governmental forms that ask for demographic data.  
28 Testimony reflected on the need for such a category while also referencing that the U.S.  
29 Federal government completed significant research on the topic and has taken steps to  
30 add this category to its census form. While testimony for the intent of Resolution 002 was  
31 positive, testimony was largely unanimous that the nearly analogous Resolution 019 better  
32 accomplishes the objectives of the authors and that Resolution 002 should not be adopted  
33 in favor of Resolution 019 being adopted instead. Notably, the authors of Resolution 002  
34 agreed with this action. Therefore, your Reference Committee recommends that  
35 Resolution 002 be not adopted.

- 36  
37 (21) RESOLUTION 021 – FREE SPEECH AND CIVIL  
38 DISCOURSE IN THE AMERICAN MEDICAL  
39 ASSOCIATION  
40

41 **RECOMMENDATION:**

42  
43 **Resolution 021 be not adopted.**

44  
45 **HOD ACTION: Resolution 021 not adopted.**

46  
47 RESOLVED, That it be the policy of our American Medical Association that:

48  
49 Our American Medical Association unequivocally commits to truly open discourse,  
50 debate, exchange of ideas, and argument;

1  
2 Our American Medical Association unequivocally commits to a culture which recognizes  
3 the inherent dignity and worth of its members, which resolves that freedom of expression  
4 and civility must coexist, and where those who disagree will do so without enmity;

5  
6 Our American Medical Association unequivocally commits to the principle that dissenting  
7 and unpopular voices must be afforded the opportunity to be heard;

8  
9 Our American Medical Association unequivocally commits that members of the  
10 American Medical Association of different faiths, philosophies, and persuasions may  
11 speak their minds and honor their deepest convictions without fear of punishment or  
12 retaliation;

13  
14 Our American Medical Association unequivocally commits that the mere exposure to  
15 ideas that some may find offensive is not an act of violence or hatred;

16  
17 Our American Medical Association unequivocally commits to a prohibition of the listing of  
18 people or organizations to be regarded as unacceptable, untrustworthy, excluded, or  
19 avoided based on ideological positions or differences;

20  
21 Our American Medical Association unequivocally commits that ideological demonization  
22 of opponents to block debate and to silence disagreement in the proceedings of the  
23 American Medical Association is unprofessional conduct subject to appropriate  
24 disciplinary action;

25  
26 Our American Medical Association unequivocally commits that defamation, obscenity,  
27 intimidation, threats, and incitement to violence, have no place in the proceedings of the  
28 American Medical Association, and if exhibited are unprofessional conduct subject to  
29 appropriate disciplinary action. (New HOD Policy)

30  
31 Your Reference Committee heard overwhelming testimony in strong opposition to  
32 Resolution 021. Speakers noted that the AMA has a Code of Conduct in place with an  
33 extensive reporting system to investigate and discipline individuals who engage in  
34 intimidation, threats or violence. Limited testimony was heard supporting reaffirmation of  
35 AMA policies G-600.054, "Procedures of the House of Delegates" and H-140.837, "Policy  
36 on Code of Conduct at AMA Meetings and Events" in lieu of the resolution. Your Reference  
37 Committee recommends that Resolution 021 be not adopted.

38  
39 Policy G-600.054, "Procedures of the House of Delegates"

40  
41 1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code  
42 of Parliamentary Procedure as our parliamentary authority, including the use of the  
43 motion to table and the motion to adopt in-lieu-of, and treat amendments by  
44 substitution as first-order amendments.

45  
46 2. The rules and procedures of the House of Delegates will be amended as  
47 follows:

1 A. The motion to table a report or resolution that has not yet been referred  
2 to a reference committee is not permitted and will be ruled out of order.  
3

4 B. A new motion is added to the House of Delegates Reference Manual,  
5 Object to Consideration. If a Delegate objects to consideration of an item  
6 of business by our HOD, the correct motion is to Object to Consideration.  
7 The motion cannot interrupt a speaker, requires a second, cannot be  
8 amended, takes precedence over all subsidiary motions and cannot be  
9 renewed. The motion requires a 3/4 vote for passage. Debate is restricted  
10 to why the item should not be considered.  
11

12 3. The procedures of our House of Delegates distinguish between a motion to  
13 refer, which is equivalent to a motion to refer for report, and a motion to refer for  
14 decision and that the motion to refer for decision be one step higher in precedence.  
15

16 4. The procedures of our House of Delegates specify that both sides must have  
17 been heard before a motion to close debate is in order and that absent an express  
18 reference to "all pending matters" the motion applies only to the matter under  
19 debate.  
20

21 5. The procedures of our House of Delegates clarify that adjournment of any House  
22 of Delegates meeting finalizes all matters considered at that meeting, meaning that  
23 items from one meeting are not subject to a motion to recall from committee, a  
24 motion to reconsider or any other motion at a succeeding meeting.  
25

26 6. The Council on Constitution and Bylaws, in consultation with the speakers, will  
27 review the House of Delegates Reference Manual and revise it accordingly.  
28

29 Policy H-140.837, "Policy on Conduct at AMA Meetings and Events"  
30

31 It is the policy of the American Medical Association that all attendees of AMA  
32 hosted meetings, events and other activities are expected to exhibit respectful,  
33 professional, and collegial behavior during such meetings, events and activities,  
34 including but not limited to dinners, receptions and social gatherings held in  
35 conjunction with such AMA hosted meetings, events and other activities.  
36 Attendees should exercise consideration and respect in their speech and actions,  
37 including while making formal presentations to other attendees, and should be  
38 mindful of their surroundings and fellow participants.  
39

40 Any type of harassment of any attendee of an AMA hosted meeting, event and  
41 other activity, including but not limited to dinners, receptions and social gatherings  
42 held in conjunction with an AMA hosted meeting, event or activity, is prohibited  
43 conduct and is not tolerated. The AMA is committed to a zero tolerance for  
44 harassing conduct at all locations where AMA business is conducted. This zero  
45 tolerance policy also applies to meetings of all AMA sections, councils,  
46 committees, task forces, and other leadership entities (each, an "AMA Entity"), as  
47 well as other AMA-sponsored events. The purpose of the policy is to protect  
48 participants in AMA-sponsored events from harm.  
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50 Definition



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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 meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:  
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and  
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

1 The Office of General Counsel will appoint a “Conduct Liaison” for all AMA House  
2 of Delegates meetings and all other AMA hosted meetings or activities (such as  
3 meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT  
4 Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports  
5 of alleged policy violations, conducting investigations, and initiating both  
6 immediate and longer-term consequences for such violations. The Conduct  
7 Liaison appointed for any meeting will have the appropriate training and  
8 experience to serve in this capacity, and may be a third party or an in-house AMA  
9 resource with assigned responsibility for this role. The Conduct Liaison will be (i)  
10 on-site at all House of Delegates meetings and other large, national AMA meetings  
11 and (ii) on call for smaller meetings and activities. Appointments of the Conduct  
12 Liaison for each meeting shall ensure appropriate independence and neutrality,  
13 and avoid even the appearance of conflict of interest, in investigation of alleged  
14 policy violations and in decisions on consequences for policy violations.

15  
16 The AMA shall establish and maintain a Committee on Conduct at AMA Meetings  
17 and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by  
18 the Office of General Counsel (or through a nomination process facilitated by the  
19 Office of General Counsel) and approved by the Board of Trustees. The CCAM  
20 should include one member of the Council on Ethical and Judicial Affairs (CEJA);  
21 provided, however, that such CEJA member on the CCAM shall be recused from  
22 discussion and vote concerning referral by the CCAM of a matter to CEJA for  
23 further review and action. The remaining members may be appointed from AMA  
24 membership generally, with emphasis on maximizing the diversity of membership.  
25 Appointments to the CCAM shall ensure appropriate independence and neutrality,  
26 and avoid even the appearance of conflict of interest, in decisions on  
27 consequences for policy violations. Appointments to the CCAM should be multi-  
28 year, with staggered terms.

## 29 30 2. Reporting Violations of the Policy

31  
32 Any persons who believe they have experienced or witnessed conduct in violation  
33 of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any  
34 AMA House of Delegates meeting or other activities associated with the AMA  
35 (such as meetings of AMA councils, sections, the RVS Update Committee (RUC),  
36 CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i)  
37 Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General  
38 Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

39  
40 Alternatively, violations may be reported using an AMA reporting hotline (telephone  
41 and online) maintained by a third party on behalf of the AMA. The AMA reporting  
42 hotline will provide an option to report anonymously, in which case the name of the  
43 reporting party will be kept confidential by the vendor and not be released to the  
44 AMA. The vendor will advise the AMA of any complaint it receives so that the  
45 Conduct Liaison may investigate.

46  
47 These reporting mechanisms will be publicized to ensure awareness.

## 48 49 3. Investigations

50

1 All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings  
2 and Events," pursuant to Section 2 above (irrespective of the reporting mechanism  
3 used) will be investigated by the Conduct Liaison. Each reported violation will be  
4 promptly and thoroughly investigated. Whenever possible, the Conduct Liaison  
5 should conduct incident investigations on-site during the event. This allows for  
6 immediate action at the event to protect the safety of event participants. When this  
7 is not possible, the Conduct Liaison may continue to investigate incidents following  
8 the event to provide recommendations for action to the CCAM. Investigations  
9 should consist of structured interviews with the person reporting the incident (the  
10 reporter), the person targeted (if they are not the reporter), any witnesses that the  
11 reporter or target identify, and the alleged violator.

12  
13 Based on this investigation, the Conduct Liaison will determine whether a violation  
14 of the Policy on Conduct at AMA Meetings and Events has occurred.

15  
16 All reported violations of the Policy on Conduct at AMA Meetings and Events, and  
17 the outcomes of investigations by the Conduct Liaison, will also be promptly  
18 transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether  
19 the Conduct Liaison determines that a violation has occurred).

20  
21 4. Disciplinary Action

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23 If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA  
24 Meetings and Events has occurred, the Conduct Liaison may take immediate  
25 action to protect the safety of event participants, which may include having the  
26 violator removed from the AMA meeting, event or activity, without warning or  
27 refund.

28  
29 Additionally, if the Conduct Liaison determines that a violation of the Policy on  
30 Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall  
31 report any such violation to the CCAM, together with recommendations as to  
32 whether additional commensurate disciplinary and/or corrective actions (beyond  
33 those taken on-site at the meeting, event or activity, if any) are appropriate.

34  
35 The CCAM will review all incident reports, perform further investigation (if needed)  
36 and recommend to the Office of General Counsel any additional commensurate  
37 disciplinary and/or corrective action, which may include but is not limited to the  
38 following:

- 39  
40 - Prohibiting the violator from attending future AMA events or activities;  
41 - Removing the violator from leadership or other roles in AMA activities;  
42 - Prohibiting the violator from assuming a leadership or other role in future AMA  
43 activities;  
44 - Notifying the violator's employer and/or sponsoring organization of the actions  
45 taken by AMA;  
46 - Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review  
47 and action;  
48 - Referral to law enforcement.

49

1 The CCAM may, but is not required to, confer with the presiding officer(s) of  
2 applicable events activities in making its recommendations as to disciplinary and/or  
3 corrective actions. Consequence for policy violations will be commensurate with  
4 the nature of the violation(s).

5  
6

#### 5. Confidentiality

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8

All proceedings of the CCAM should be kept as confidential as practicable.  
9 Reports, investigations, and disciplinary actions under Policy on Conduct at AMA  
10 Meetings and Events will be kept confidential to the fullest extent possible,  
11 consistent with usual business practices.

12  
13

#### 6. Assent to Policy

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15

As a condition of attending and participating in any meeting of the House of  
16 Delegates, or any council, section, or other AMA entities, such as the RVS Update  
17 Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA  
18 hosted meeting or activity, each attendee will be required to acknowledge and  
19 accept (i) AMA policies concerning conduct at AMA HOD meetings, including the  
20 Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication  
21 and disciplinary processes for violations of such policies (including those  
22 implemented pursuant to these Operational Guidelines), and all attendees are  
23 expected to conduct themselves in accordance with these policies.

24  
25

Additionally, individuals elected or appointed to a leadership role in the AMA or its  
26 affiliates will be required to acknowledge and accept the Policy on Conduct at AMA  
27 Meetings and Events and these Operational Guidelines.

28  
29

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events  
30 may be reported at 800.398.1496 or online at [https://www.lighthouse-  
31 services.com/ama](https://www.lighthouse-services.com/ama). Both are available 24 hours a day, 7 days a week.

32  
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Please note that situations unrelated to this Policy on Conduct at AMA Meetings  
34 and Events should not be reported here. In particular, patient concerns about a  
35 physician should be reported to the state medical board or other appropriate  
36 authority.]

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39 (22) RESOLUTION 022 – PROHIBITION OF RACIST  
40 CHARACTERIZATION BASED ON PERSONAL  
41 ATTRIBUTES

42  
43

#### **RECOMMENDATION:**

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45

**Resolution 022 be not adopted.**

46  
47

**HOD ACTION: Resolution 022 not adopted.**

48  
49

RESOLVED, That it be the policy of our American Medical Association that no  
50 person or group of persons shall be considered or characterized as racist based on

1 personal attributes of race, color, religion, sex (including pregnancy, sexual  
2 orientation, or gender identity), national origin, age, disability, or genetic  
3 information. (New HOD Policy)

4  
5 Significant testimony was heard in opposition to Resolution 022. Speakers noted that  
6 racism is structural, not personal, and passing this resolution could undermine recent and  
7 ongoing work by the AMA to address systemic racism in the health care system. It was  
8 noted that the AMA has established policy on racism, and limited testimony suggested  
9 reaffirmation of existing AMA policy in lieu of this resolution. It was also noted that our  
10 AMA has extensive guidelines on ethical and professional behavior to which all should  
11 adhere. Limited supporting testimony suggested that the resolution should pass, and that  
12 no physician should be considered to be racist based on personal attributes. Your  
13 Reference Committee does not believe that it is the place of the AMA or AMA policy to  
14 determine who is or is not racist on an individual level, and therefore recommends that  
15 Resolution 022 be not adopted.

- 1 Doctor Speaker, this concludes the report of the Reference Committee on Amendments
- 2 to Constitution and Bylaws. I would like to thank George A. Fouras, MD, Tate Hinkle, MD,
- 3 Theodore Jones, MD, Candace E. Keller, MD, Robert Panton, MD and Abhishek Dharan.
- 4 I would also like to thank our staff and all those who testified before the Committee.

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Abhishek Dharan  
Texas, Regional Medical Student

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Theodore Jones, MD  
Michigan (Alternate)

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George A. Fouras, MD  
California

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Candace E. Keller, MD  
American Society of Anesthesiologists

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Tate Hinkle, MD  
American Academy of Family  
Physicians (Alternate)

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Robert Panton, MD  
Illinois

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Heidi Dunniway, MD  
Indiana (Alternate)  
Chair