

Reference Committee on Amendments to Constitution and Bylaws

Report(s) of the Board of Trustees

- 02 New Specialty Organizations Representation in the House of Delegates

Report(s) of the Council on Constitution and Bylaws

- 01 AMA Bylaws—Nomination of Officers and Council Members
- 02 AMA Bylaws—Run-Off and Tie Ballots
- 03 AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)
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- 014 The Preservation of the Primary Care Relationship
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- 017 Addressing the Historical Injustices of Anatomical Specimen Use
- 018 Opposing Violence, Terrorism, Discrimination, and Hate Speech
- 019 Supporting the Health of Our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 022 Health and Racial Equity in Medical Education to Combat Workforce Disparities

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-24

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the
2 applications of the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle
3 Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society for
4 Pediatric Dermatology for national medical specialty organization representation in the American
5 Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by
6 the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

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8 The applications were considered using criteria developed by the Council on Long Range Planning
9 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

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11 Organizations seeking admission were asked to provide appropriate membership information to the
12 AMA. That information was analyzed to determine AMA membership, as required under criterion
13 three. A summary of this information is attached to this report as Exhibit B.

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15 In addition, organizations must submit a letter of application in a designated format. This format
16 lists the above-mentioned guidelines followed by each organization's explanation of how it meets
17 each of the criteria.

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19 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.
20 These organizations have actively participated in the SSS for more than three years.

21
22 Review of the materials and discussion during the SSS meeting at the November 2023 Interim
23 Meeting indicated that the Academy of Consultation-Liaison Psychiatry, American College of
24 Lifestyle Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society
25 for Pediatric Dermatology meet the criteria for representation in the HOD.

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27 **RECOMMENDATION**

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29 Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry,
30 American College of Lifestyle Medicine, American Venous Forum, Association of Academic
31 Psychiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of
32 Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX
Exhibit A

**GUIDELINES FOR REPRESENTATION IN & ADMISSION TO
THE HOUSE OF DELEGATES:**

National Medical Specialty Societies

- 1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
- 2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
- 3) The organization must meet one of the following criteria:
 - 1,000 or more AMA members;
 - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
- 4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.
- 5) Physicians should comprise the majority of the voting membership of the organization.
- 6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.
- 7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.
- 8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
- 9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
- 10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Consultation-Liaison Psychiatry	378 of 1,471 (26%)
American College of Lifestyle Medicine	974 of 3,937 (25%)
American Venous Forum	115 of 439 (26%)
Association of Academic Physiatrists	162 of 779 (21%)
Society for Pediatric Dermatology	154 of 564 (27%)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-24

Subject: AMA Bylaws—Nomination of Officers and Council Members

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting, the House of Delegates adopted Recommendation 21 of Speakers
2 Report 3, Report of the Election Task Force 2 (Policy G-610.089). Policy G-610.089 directed that
3 Bylaw 6.8.1 be updated to clarify that nominations are made by the chair of the Board of Trustees
4 or by a member of the House of Delegates at the opening session of the meeting at which elections
5 take place. The Council found similar language in Bylaw 3.3. To maintain internal bylaw
6 consistency and to accurately describe the nomination process for Officers and Council members
7 the Council submits amended language for 3.3 and 6.8.1 for House action.

8 9 RECOMMENDATIONS

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11 The Council on Constitution and Bylaws recommends that the following amendments to our AMA
12 Bylaws be adopted, that Policy G-610.989 be rescinded, and that the remainder of this report be
13 filed. Adoption requires the affirmative vote of two-thirds of the members of the House of
14 Delegates present and voting.

15 16 **3 Officers**

17 ***

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19
20 **3.3 Nominations.** Nominations for President-Elect, Speaker and Vice Speaker, shall be
21 made ~~from the floor~~ by a member of the House of Delegates at the opening session of
22 the meeting at which elections take place. Nominations for all other officers, except for
23 Secretary, the medical student trustee, and the public trustee, shall be made ~~from the~~
24 ~~floor~~ by a member of the House of Delegates at the opening session of the meeting at
25 which elections take place ~~and may be announced by the Board of Trustees.~~

26 27 **6 Councils**

28 ***

29 30 31 **6.8 Election – Council on Constitution and Bylaws, Council on Medical Education,** 32 **Council on Medical Service, and Council on Science and Public Health**

33
34 **6.8.1 Nomination and Election.** Members of these Councils, except the medical
35 student member, shall be elected by the House of Delegates. The Chair
36 ~~Nominations shall be made by the chair~~ of the Board of Trustees will present
37 announced candidates, who shall be entered into nomination by the Speaker
38 at the Opening session of the meeting at which elections take place.

1 Nominations ~~and~~ may also be made from the floor by a member of the
2 House of Delegates at the opening session of the meeting at which elections
3 take place.

4
5 (Modify Bylaws)

Fiscal Note: No Significant Fiscal Impact

RELEVANT AMA POLICY

G-610.089, Directives on Nominations from Speakers Report 3. The language in Bylaw 6.8.1, “Nomination and Election” be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 02-A-24

Subject: AMA Bylaws—Run-Off and Tie Ballots
(Report of ETF 2 - Rec. #13)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting of the American Medical Association (AMA) the House of Delegates
2 (HOD) considered Recommendation 13 from Speakers Report 3, Report of the Election Task Force
3 2, that asked that Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for
4 elections of officers and councils with multiple nominees so that the lowest vote getter on each
5 ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in
6 which case both would be dropped. While the Reference Committee recommended adoption of
7 Recommendation 13, the HOD ultimately referred the recommendation over concerns about
8 complex onsite bylaw language not being able to be considered at caucuses.

9
10 The AMA has a long-standing precedent of requiring that all office holders are elected by a
11 majority of those casting legal ballots. During Council on Constitution and Bylaws (the Council)
12 discussions of potential bylaw language, it became apparent that there are three very unlikely
13 scenarios in which a strict elimination of the nominee with the lowest vote tally as proposed in the
14 Speakers 3-I-23 would enable a nominee who had not received a majority of votes cast to be
15 elected:

- 16
17 • For example, if five nominees were running for four vacancies on the Board of Trustees (or
18 an elected Council), and only three receive a majority of votes, then, of the remaining two,
19 one would be eliminated, effectively installing a nominee who had not yet received a
20 majority of votes.
- 21 • Even more unlikely, albeit possible, is a situation whereby those two remaining candidates
22 tie, and subsequently would then both be eliminated if the Bylaws were strictly interpreted.
- 23 • A similar but even more unlikely event could occur in an election for an officer. For
24 example, if three nominees (A, B, and C) were running for Speaker in a House of 100
25 votes, then it is possible that A could receive 34 votes, and B and C could each receive 33.
26 Again, a strict interpretation of the rule would eliminate both B and C, effectively
27 installing a Speaker who had not received a majority of votes.
- 28 • The Council noted that a more common occurrence is a multi-vacancy, multi-nominee race
29 with one more nominee than there are vacancies. For such a race, a more likely outcome is
30 that two nominees do not attain a majority vote with only one vacancy remaining. and must
31 run against each other for the remaining vacancy.
- 32 • Lastly, the Council noted that were elections held at the I-23 meeting with a potential of
33 705 credentialed delegates, theoretically a contested race with three nominees could end in
34 a three-way tie (with each nominee receiving 235 votes).

1 Admittedly, these are highly unlikely scenarios, but for completeness, your Council on Constitution
2 and Bylaws felt they should be addressed to avoid controversy should they occur. Minor
3 conditional language has been added in order to prevent such scenarios.

4
5 RECOMMENDATIONS

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

10
11 **3 Officers**

12 ***

13 **3.4 Elections.**

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15 **3.4.2 Method of Election.** Where there is no contest, a majority vote without ballot shall
16 elect. All other elections shall be by ballot.

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18 **3.4.2.1 At-Large Trustees.**

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20 **3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee
21 shall be listed alphabetically on a single ballot. Each elector
22 shall have as many votes as the number of Trustees to be
23 elected, and each vote must be cast for a different nominee.
24 No ballot shall be counted if it contains fewer or more votes
25 than the number of Trustees to be elected, or if the ballot
26 contains more than one vote for any nominee. A nominee shall
27 be elected if they have received a vote on a majority of the
28 legal ballots cast and are one of the nominees receiving the
29 largest number of votes within the number of Trustees to be
30 elected.

31
32 ~~**3.4.2.1.2 Runoff Ballot.** A runoff election shall be held to fill any
33 vacancy not filled because of a tie vote.~~

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35 ~~**3.4.2.1.2**~~ **3.4.2.1.2³ Subsequent Ballots.** If all vacancies for Trustees are not filled
36 on the first ballot, and there are more than two remaining
37 nominees, the nominee with the fewest votes shall be dropped
38 and the remaining nominees shall be placed on the subsequent
39 ballot. In the event of a tie for the fewest votes, both
40 nominees shall be dropped. If these actions would result in
41 fewer than two nominees, the nominee(s) with the fewest
42 votes shall not be dropped and all remaining nominees shall be
43 placed on the subsequent ballot. On any subsequent ballot, a
44 nominee shall be elected if they have received a vote on a
45 majority of the legal ballots cast and are one of the nominees
46 receiving the larger number of votes within the number of
47 Trustees to be elected or remaining to be elected. and 3 or
48 more Trustees are still to be elected, the number of nominees
49 on subsequent ballots shall be reduced to no more than twice

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~~the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.~~

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6 Councils

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

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions result in fewer than two nominees, the nominees with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure

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shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. ~~A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.~~

6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two remaining nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of council members to be elected or remaining to be elected. and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee. This procedure shall be repeated until all vacancies have been filled.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 03-A-24

Subject: AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting of the American Medical Association (AMA), the House of Delegates
2 adopted as amended Recommendation 26 from Speakers Report 3: Report of the Election Task
3 Force 2 (D-610.997). Policy [D-610.997](#) asked that our AMA consider developing bylaw language
4 regarding the removal of elected individuals or candidates and the criteria by which such removal
5 would be accomplished and to report back at A-24.

6
7 The Council on Constitution and Bylaws (the Council) has developed this report specifically to
8 comprehensively address the removal of officers, council members, and section governing council
9 members. The report does not address candidates as the Council strongly believes this is more
10 appropriately addressed by the Election Committee. Successfully elected candidates would be
11 considered officers or council members and would be covered under the Council’s
12 recommendations in this report.

13
14 Recommendations are presented for consideration by the House of Delegates.

15 16 BACKGROUND

17
18 As part of its fact-finding mission, the Council reviewed applicable bylaws, policies and statutes
19 that address the removal of such parties from office:

20 21 Bylaws

- 22
- 23 • AMA Bylaw [3.2.1](#) specifies that AMA membership is a condition for holding office.
24 Nonrenewal of AMA membership would make a candidate or incumbent ineligible to hold
25 office.
 - 26 • AMA Bylaws for the Resident/Fellow Trustee [[3.5.5.1](#)] and the Medical Student Trustee
27 [[3.5.6.3](#)] have provisions specifying termination of their terms should they no longer
28 qualify as a resident/fellow or medical student (there also is a grace period if this occurs
29 within 90 days of the annual meeting). Similar bylaw provisions exist for residents and
30 medical student members of AMA councils [[6.11](#)].
 - 31 • Bylaw [1.5](#) states that the Council on Ethical and Judicial Affairs (CEJA) after due notice
32 and hearing, may censure, expel, or place on probation any member of the AMA for an

1 infraction of the Constitution or these Bylaws, for violation of the Principles of Medical
2 Ethics, or for unethical or illegal conduct.

- 3 • Bylaw [3.6.4](#) states that if an officer misses six consecutive regular meetings of the Board of
4 Trustees (Board), this matter shall be reported to the House of Delegates by the Board and
5 the office shall be considered vacant.
- 6 • AMA Bylaws provide a mechanism for filling vacancies for all Officers and for the elected
7 and appointed Councils.
- 8 • AMA Bylaws do not prohibit the resignation of any Board member or Council member for
9 any reason.
- 10 • AMA's Parliamentary Authority, as specified in Bylaw [11.1](#) is the current edition of The
11 American Institute of Parliamentarians Standard Code of Parliamentary Procedure
12 (AIPSC). AIPSC (2nd ed.) acknowledges in Section 3.15 the rights of an organization to
13 discipline, suspend and/or expel members, directors and officers in accordance with its
14 bylaws, the parliamentary authority, and within the law.

15 16 Policies

- 17
18 • The [AMA Principles of Medical Ethics](#) ("Principles") were last revised in June 2001 but
19 initially adopted as the AMA's Code of Conduct when AMA was formed in 1847. The
20 Principles are standards of conduct that define the essentials of honorable behavior for
21 physicians. Principles applicable to this report include:
 - 22 ○ II. A physician shall uphold the standards of professionalism, be honest in all
23 professional interactions, and strive to report physicians deficient in character or
24 competence, or engaging in fraud or deception, to appropriate entities.
 - 25 ○ III. A physician shall respect the law and also recognize a responsibility to seek
26 changes in those requirements which are contrary to the best interests of the
27 patient.
 - 28 ○ IV. A physician shall respect the rights of patients, colleagues, and other health
29 professionals, and shall safeguard patient confidences and privacy within the
30 constraints of the law.
- 31
32 • Policy [H-140.837](#), "Policy on Conduct at AMA Meetings and Events," includes language
33 to the effect that "The CCAM (Committee on Conduct at AMA Meetings and Events) will
34 review all incident reports, perform further investigation (if needed) and recommend to the
35 Office of General Counsel any additional commensurate disciplinary and/or corrective
36 action, which may include but is not limited to the following: prohibiting the violator from
37 attending future AMA events or activities; removing the violator from leadership or other
38 roles in AMA activities; prohibiting the violator from assuming a leadership or other role
39 in future AMA activities; notifying the violator's employer and/or sponsoring organization
40 of the actions taken by AMA; referral to the CEJA for further review and action; and
41 referral to law enforcement.

42 43 Law

- 44
45 • Our AMA is incorporated in the State of Illinois under the General Not For Profit
46 Corporation Act of 1986 (the "Act"). As such, the following provisions apply:
47
48 Sec. 108.35. Removal of directors.
49 (a) One or more of the directors may be removed, with or without cause. In the case of a
50 corporation having a board of directors which is classified in accordance with

1 subsection 108.10(e) of this Act, the articles of incorporation or bylaws may provide
2 that such directors may only be removed for cause.
3 (b) In the case of a corporation with no members or with no members entitled to vote on
4 directors, a director may be removed by the affirmative vote of a majority of the
5 directors then in office present and voting at a meeting of the board of directors at
6 which a quorum is present.
7 (c) In the case of a corporation with members entitled to vote for directors, no director may
8 be removed, except as follows:
9 (1) A director may be removed by the affirmative vote of two-thirds of the votes present
10 and voted, either in person or by proxy.
11 (2) No director shall be removed at a meeting of members entitled to vote unless the
12 written notice of such meeting is delivered to all members entitled to vote on removal of
13 directors. Such notice shall state that a purpose of the meeting is to vote upon the
14 removal of one or more directors named in the notice. Only the named director or
15 directors may be removed at such meeting.
16 (3) In the case of a corporation having cumulative voting, if less than the entire board is
17 to be removed, no director may be removed, with or without cause, if the votes cast
18 against his or her removal would be sufficient to elect him or her if then cumulatively
19 voted at an election of the entire board of directors.
20 (4) If a director is elected by a class of voting members entitled to vote, directors or
21 other electors, that director may be removed only by the same class of members entitled
22 to vote, directors or electors which elected the director.
23 (d) The provisions of subsections (a), (b) and (c) shall not preclude the Circuit Court from
24 removing a director of the corporation from office in a proceeding commenced either by
25 the corporation or by members entitled to vote holding at least 10 percent of the
26 outstanding votes of any class if the court finds (1) the director is engaged in fraudulent
27 or dishonest conduct or has grossly abused his or her position to the detriment of the
28 corporation, and (2) removal is in the best interest of the corporation. If the court
29 removes a director, it may bar the director from reelection for a period prescribed by the
30 court. If such a proceeding is commenced by a member entitled to vote, such member
31 shall make the corporation a party defendant.
32 (Source: P.A. 96-649, eff. 1-1-10.)
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- 34 • While the AMA’s Office of the General Counsel (OGC) notes that the Act does not
35 directly apply to elected or appointed Council members or appointed committee members,
36 it should be noted that the Illinois statute is broad and vague. Thus, our AMA is fully
37 empowered and has the authority to provide that “all elected and/or appointed individuals”
38 would be required to be bound by the removal language in the statute if it so desired.
39 Lastly, OGC advised that whatever is the final determination of the House of Delegates
40 (the “House”), to the extent it conflicts with Illinois law, Illinois law will govern.
41

42 DISCUSSION

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44 As part of its fact-finding, the Council read with interest an article from the American Hospital
45 Association’s Trustee Insights, entitled “When a Board Member Crosses the Line: Removing a
46 Trustee Midterm,¹ whereby organizations are urged to define the desired behaviors of its board
47 members, clarify behaviors that are clearly unacceptable and create a standard process to

¹ Orlikoff, J, When a Board Member Crosses the Line: Removing a Trustee Midterm: Addressing problem behaviors is key to a high performing board. AHA Trustee Insights, September 2023
[\[https://trustees.aha.org/when-board-member-crosses-line-removing-trustee-midterm\]](https://trustees.aha.org/when-board-member-crosses-line-removing-trustee-midterm)

1 immediately address them if exhibited by any board member. Board members are classified into
2 four categories: superstars, solid performers, nonperforming/deadweight members, and toxic
3 members. While nonperforming members are typically managed by an organization through peer
4 pressure, not being re-elected or appointed, or resignations due to personal or health reasons, the
5 article supports removal of a toxic member for reasons such as violating the conflict-of-interest
6 policy, including failure to disclose a conflict; attempting to use information obtained as a board
7 member in such a way as to derive personal, financial or other benefit; violating the confidentiality
8 policy; verbally abusing board members, staff or patients/families; any physical assault on board
9 members, staff or patients/families at any time, in any place; actively working to subvert stated
10 board policy or decisions; accusation or conviction of felony; speaking against the organization or
11 the board or the CEO or staff in public; or racist or sexist comments or behavior, failure to attend a
12 minimum of 50% (or other specified percentage) of board meetings; failing to attend three
13 consecutive board meetings; and sleeping during board or board committee meetings (two or more
14 instances).

15

16 The Council notes that the Standing Rules of the AMA Board of Trustees provide for the removal
17 of the chair-elect or chair, positions elected internally by Board members. The Council also
18 emphasizes that existing AMA bylaws, policies and Illinois law cover most but not all, of the other
19 behaviors defined as unacceptable.

20

21 In further discussing the issue, the Council noted that only AMA Trustees have a fiduciary
22 responsibility, and those who do not complete their responsibilities (through negligence or blatant
23 recklessness) could cause the AMA to incur unnecessary liability.

24

25 The Council also found that while the Speakers Report did not address the removal of individuals
26 who serve on appointed councils, the Council believes there should be a comparable process for
27 removal similar to those who serve on elected councils, with those procedures to be adopted by the
28 House. Similarly, while Section governing council members have no fiduciary responsibilities, the
29 bylaws also should incorporate a removal provision, with those Rules to be approved by the AMA
30 Board of Trustees. Several Section Internal Operating Procedures already provide for the removal
31 of a governing council member. The Council would work collaboratively with the Council on Long
32 Range Planning and Development, CEJA, OGC, and the House of Delegates to develop the
33 procedures to be employed.

34

35 In perusing other published literature, personal one-on-one intervention is often cited as a less
36 formal solution to managing problematic board, council or committee members. For example, if an
37 individual has failed to attend a specified number of meetings in a row, has a specified number of
38 unexcused absences or has become an impediment to the group's work, the most senior member
39 often meets informally with the individual in question. Additionally, offering or granting a leave of
40 absence is another option to make it possible for individuals to take a leave of absence from a
41 board, council or committee if they have health, work or other reasons why they cannot participate
42 fully during the current term. AMA Bylaws, Council Rules and Section Internal Operating
43 Procedures all provide a mechanism for filling vacancies. Lastly, term limits are cited as ways to
44 minimize less than effective performance, and there are already term limits for AMA Trustees,
45 Council members and Section governing council members in place.

46

47 The Council learned that the bylaws or governing documents of several other organizations
48 incorporated in Illinois, such as the American Dental Association, American Bar Association,
49 Illinois Association for Behavior Analysis, include provisions that allow for the removal of elected
50 trustees, council members or committee members, with varying language and detail:

- 1 • **American Dental Association:** ADA Bylaws state that “The House of Delegates may
2 remove a trustee for cause in accordance with procedures established by the House of
3 Delegates. The procedures shall provide for notice of the charges alleged and an
4 opportunity for the accused to be heard in their defense. A two-thirds (2/3) affirmative vote
5 of the delegates present and voting is required to remove a trustee from office.” The ADA
6 Governance Manual provides further details that include: The House of Delegates may
7 remove an elective officer for cause in accordance with procedures established by the
8 House of Delegates. The procedures shall provide for notice of the charges alleged and an
9 opportunity for the accused to be heard in his or her defense. A two-thirds (2/3) affirmative
10 vote of the delegates present and voting is required to remove a trustee from office.
11
- 12 • Similarly, the ADA Governance Manual includes language to address removal of elected
13 or appointed Council members: “Removal for Cause. The Board of Trustees may remove a
14 council member for cause in accordance with procedures established by the Board of
15 Trustees. Those procedures shall provide for notice of the charges, including allegations of
16 the conduct purported to constitute each violation and a decision in writing which shall
17 specify the findings of fact which substantiate any and all of the charges. Prior to issuance
18 of the decision by the Board of Trustees, no council member shall be excused from
19 attending any meeting of a council unless there is an opportunity to be heard or compelling
20 reasons exist which are specified in writing by the Board of Trustees.” Similar language
21 also exists for the removal of Commission members, “Removal for Cause. Any of the
22 commissions of this Association shall have the sole authority to remove any of its members
23 for cause pursuant to its Rules, with notice of such removal being given to the ADA Board
24 of Trustees.”
25
- 26 • **Illinois Association for Behavior Analysis -- Removal of Board Member.** An elected
27 Board Member may be removed from their positions on the Board without cause if such
28 removal is approved by a majority vote of the membership. An appointed Board Member
29 may be removed by a majority vote of the Board.
30
- 31 • **American Psychological Association --** If a standing board or committee believes that
32 there is reasonable cause to remove a member from said body, a vote may be taken by the
33 board or committee to petition the Board of Directors to remove said member. If, with the
34 exception of the individual in question, two-thirds of all members vote to remove said
35 member, then a petition requesting removal shall inform the Board of Directors of the basis
36 for, and the evidence supporting, said removal. The Board of Directors shall give said
37 member the opportunity to fully respond in writing to the petition. The Board of Directors,
38 by a two-thirds vote of all members, may remove said member if it determines that there is
39 reasonable cause for removal and that removal is in the best interest of the Association.
40
- 41 • **American Bar Association –** Bylaw 31.2 allows the President to replace any committee
42 member who does not participate in the activities of the committee.
43

44 In conclusion, the Council supports bylaw language that addresses removal of individuals currently
45 holding a position within the AMA in accordance with procedures approved by the House or the
46 Board of Trustees. While removal is already possible under Illinois statute, the Council would
47 support bylaw language for the sake of transparency.

1 RECOMMENDATIONS

2
3 The Council on Constitution and Bylaws recommends that the following recommendations be
4 adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed.

- 5
6 1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption
7 requires the affirmative vote of two-thirds of the members of the House of Delegates
8 present and voting:
9

10 **3. Officers**

11 ***

12
13
14 **3.6 Vacancies.**

15 ***

16
17 **3.6.4 Absences.** If an officer misses 6 consecutive regular meetings of the Board,
18 this matter shall be reported to the House of Delegates by the Board of
19 Trustees and the office shall be considered vacant. The vacancy shall be filled
20 as provided in Bylaw 3.6.1 or Bylaw 3.6.3.

21
22 **3.6.5 Removal for Cause.** Any officer may be removed for cause in accordance
23 with procedures established by the House of Delegates.

24
25 **6. Councils**

26 ***

27
28
29 **6.0.1.4 Removal.** A Council member may be removed for cause in accordance with
30 procedures approved by the House of Delegates.

31
32 **7. Sections**

33 ***

34
35
36 **7.0.3.4 Removal.** A Governing Council member may be removed for cause in
37 accordance with procedures approved by the House of Delegates.

38
39 (Modify Bylaws)

- 40
41 2) That the Councils on Constitution and Bylaws, Long Range Planning and Development
42 and the Ethical and Judicial Affairs and the House develop the procedures to remove a
43 trustee, council member or governing council member for cause. (Directive to Take
44 Action)
45
46 3) That the Election Committee address the need for policy to remove candidates who are
47 found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles.
48 (Directive to Take Action)

Fiscal Note: No Significant Fiscal Impact

RELEVANT AMA POLICY

D-610.997, Criteria Regarding Removal of Elected Individuals or Candidates
Our American Medical Association will consider developing bylaw language regarding removal of elected individuals or candidates and the criteria by which this would be accomplished and to report back at A-24.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 04-A-24

Subject: AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 American Medical Association (AMA) Bylaw 11.1 states that “In the absence of any provisions to
2 the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all
3 meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and
4 committees shall be governed by the parliamentary rules and usages contained in the then current
5 edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.”
6 The most recent edition of the AIP Standard Code [herein referred to as AIPSC (2nd ed.)] became
7 effective as of January 2024.

8
9 As noted in informational Speakers Report 3, AIPSC (2nd ed.) establishes electronic notice as the
10 default notification and there are several AMA bylaw provisions that specify notification by mail
11 and/or in writing. The Council has prepared bylaw language to ensure that our Bylaws and AIPSC
12 (2nd ed.) are consistent.

13
14 **RECOMMENDATIONS**

15
16 The Council on Constitution and Bylaws recommends that the following recommendations be
17 adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of
18 two-thirds of the members of the House of Delegates present and voting:

- 19
20 1) That our AMA Bylaws be amended by insertion and deletion as follows:

21
22 **2.12.2 Special Meetings of the House of Delegates.** Special Meetings of the House of
23 Delegates shall be called by the Speaker on ~~written or electronic~~ request by of one third of
24 the members of the House of Delegates, or on request of a majority of the Board of
25 Trustees. When a special meeting is called, the Executive Vice President of the AMA shall
26 notify ~~mail a notice to the last known address of~~ each member of the House of Delegates at
27 least 20 days before the special meeting is to be held. The notice shall specify the time and
28 place of meeting and the purpose for which it is called, and the House of Delegates shall
29 consider no business except that for which the meeting is called.

30
31 ***

32
33 **2.12.3.1 Invitation from Constituent Association.** A constituent association desiring a
34 meeting within its borders shall submit an invitation ~~in writing~~, together with significant
35 data, to the Board of Trustees. The dates and the city selected may be changed by action of

1 the Board of Trustees at any time, but not later than 60 days prior to the dates selected for
2 that meeting.

3 ****

4
5 **5.2.4 Notice of Meeting.** Notice is given if delivered in person, by telephone, ~~mail~~, or any
6 means of electronic communication approved by the Board of Trustees. Notice shall be
7 deemed to be received upon delivery to the Trustee's contact information then appearing
8 on the records of the AMA.

9
10 **5.2.4.1 Waiver of Notice.** ~~Notice of any meeting need not be given if waived in~~
11 ~~writing before, during or after such meeting.~~ Attendance at any meeting shall constitute
12 a waiver of notice of such meeting, except where such attendance is for the express
13 purpose of objecting to the transacting of any business because of a question as to the
14 legality of the calling or convening of the meeting.

15
16 ****

17
18 **12.3 Articles of Incorporation.** The Articles of Incorporation of the AMA may be
19 amended at any regular or special meeting of the House of Delegates by the approval of
20 two-thirds of the voting members of the House of Delegates registered at the meeting,
21 provided that the Board of Trustees shall have approved the amendment and provided it to
22 ~~submitted it in writing to~~ each member of the House of Delegates at least 5 days, but not
23 more than 60 days, prior to the meeting of the House of Delegates at which the amendment
24 is to be considered.

25
26 (Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-24

Subject: Short-Term Global Health Clinical Encounters

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Short-term global health clinical encounters deploy physicians and physicians in training from
2 wealthy communities to provide care in under-resourced settings for a period of days or weeks.
3 They have been promoted, in part, as a strategy for addressing global health inequities, and have
4 unquestionably benefitted thousands of individual patients. At the same time, these trips have a
5 problematic history and run the risk of causing harm to the patients and communities they intend to
6 benefit [1]. To minimize harm and ensure significant benefits, participants, sponsors, and hosts
7 must jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day
8 collaboration across differences of culture, language, and history; and fairly allocate host and team
9 resources.

10
11 Ethics guidance can neither redress historical wrongs nor solve the underlying structural issues that
12 drive medical need in under-resourced settings. However, by making explicit the conditions under
13 which short-term global health clinical encounters are ethically sound and articulating the
14 fundamental ethical responsibilities of those who participate in and sponsor such trips, ethics
15 guidance can promote immediate benefit to individuals and sustainable benefit for host
16 communities. In addition, ethics guidance can highlight the ways in which power imbalances and
17 neo-colonial assumptions can shape these practices and so may undermine their moral
18 acceptability. This report by the Council on Ethical and Judicial Affairs (CEJA) explores the
19 challenges of short-term global health clinical encounters and offers guidance for physicians,
20 physicians in training, and sponsors to help them address the ethical challenges of providing
21 clinical care in under-resourced settings. The encounters and perspective of host communities may
22 reveal concerns not specifically addressed in this report. However, the guidance provided
23 emphasizes the critical importance of ethical intent and collaboration with host communities, thus
24 encouraging ongoing conversations between visiting medical teams and host communities
25 regarding cultural, ethical, and practical concerns.

26 27 THE APPEAL OF SHORT-TERM GLOBAL HEALTH CLINICAL ENCOUNTERS

28
29 Just how many clinicians and trainees volunteer to provide medical care in under-resourced settings
30 is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the
31 nearly 3 billion dollars' worth of participant hours spent in international efforts in 2007 were
32 medically related [2]. For trainees, in January 2015 the Consortium of Universities for Global
33 Health identified more than 180 websites relating to global health opportunities [3]. The

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

1 Association of American Medical Colleges found that among students who graduated in 2017–
2 2018 between 25% and 31% reported having had some “global health experience” during medical
3 school [4].
4

5 A variety of reasons motivate physicians and trainees to participate in these projects. For many,
6 compelling motivations include the opportunities to help address health inequities, improve their
7 diagnostic and technical skills as clinicians, or explore global health as a topic of study [2]. Global
8 health clinical encounters may also be pursued to serve the goals of building one’s resume,
9 improving one’s professional prospects, and gaining the esteem of peers and family [2].
10

11 A NOTE ON TERMINOLOGY

12

13 The literature is replete with different terms for the activity of traveling to an under-resourced
14 community to provide medical care on a volunteer basis, including “short-term medical
15 volunteerism” [5], “short-term medical missions” [6], “short-term medical service trips” [7,8],
16 “short-term experience in global health” [9,10], “global health field experience” [11], “global
17 health experience,” and “international health experience”[2].
18

19 The Council on Ethical and Judicial Affairs prefers “short-term global health clinical encounters.”
20 This identifier is generally accepted and encompasses both clinical and educational activities. It
21 also recognizes that such encounters are not exercises in pure altruism, but a mutually beneficial
22 collaboration between those planning and participating in these encounters and host communities.
23 The term also highlights the fact that these activities are limited in duration, which has implications
24 for the ethical obligations of participants and their impact on host communities.
25

26 MEDICAL CARE IN UNDER-RESOURCED SETTINGS

27

28 Traditionally, short-term global health clinical encounters focused on providing clinical care as a
29 charitable activity, not infrequently under the auspices of faith-based institutions, whose primary
30 goal was to address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of
31 improving the health and well-being of host communities [9]. Many also offer training
32 opportunities for medical students, residents, and local healthcare professionals [9,10,11]. Ideally,
33 short-term global health clinical encounters are part of larger, long-term efforts to build capacity in
34 the health care systems being visited, and ultimately to reduce global health disparities [9,10].
35

36 The medical needs of host communities differ from those of participants’ home countries—
37 participants may encounter patients with medical conditions they have not seen before, or who
38 present at more advanced stages of disease, or are complicated by “conditions, such as severe
39 malnutrition, for which medical volunteers may have limited experience” [7]. At the same time,
40 available treatment options will often include medications, procedures or tools with which
41 participants are not familiar. As such, the practice of medicine in under-resourced communities
42 should be considered a unique area of expertise, requiring specific background and training in order
43 to be effective [12].
44

45 By definition, short-term global health clinical encounters typically take place in contexts of scarce
46 resources. The communities where these encounters take place often have limited access to health
47 care, often lack access to food, and often lack both economic and political power [7]. As a result,
48 they may feel unable to refuse assistance that is offered [10]. Moreover, short-term global health
49 clinical encounters take place under the long shadow of colonialism, including medicine’s role in
50 that [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and
51 dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should

1 recognize that it is a privilege to practice and train in under-resourced communities, and that justice
2 requires reciprocity and equal respect among local and visiting staff, community members, and
3 patients in this context [9].

4
5 These realities define fundamental ethical responsibilities not only for those who volunteer, but
6 equally for the individuals and organizations that sponsor short-term global health clinical
7 encounters.

8 9 ETHICAL RESPONSIBILITIES IN SHORT-TERM GLOBAL HEALTH CLINICAL 10 ENCOUNTERS

11
12 Emerging guidelines identify the following ethical duties for participants of short-term global
13 health clinical encounters and organizations sponsoring them: (a) to produce good clinical
14 outcomes, (b) to promote justice and sustainability, (c) to minimize burdens on host communities,
15 and (d) to respect persons and local cultures [2,9,10,11].

16 17 Promoting Justice & Sustainability

18
19 If short-term global health clinical encounters are to achieve their goal of improving the health of
20 local host communities, they must commit not simply to addressing immediate, concrete needs, but
21 to helping the community build its own capacity to provide health care. To that end, the near and
22 longer-term goals of trips should be set in collaboration with the host community, not determined
23 in advance solely by the interests or intent of trip sponsors and participants [7,9]. Trips should seek
24 to balance community priorities with the training interests and abilities of participants [10], but in
25 the first instance benefits should be those desired by, and acceptable to, the host community [9].
26 Those involved with short-term global health clinical encounters have a responsibility to ask how
27 they can best use a trip's limited time and material resources to promote the long-term goal of
28 developing local capacity. Will the trip train local health care providers? Build local infrastructure?
29 [7]? Ideally, a short-term global health experience will be embedded in a longer-term strategy and
30 collaboratively planned with the host community [7,10].

31 32 Minimizing Harms & Burdens in Host Communities

33
34 Just as focusing on the overarching goal of promoting justice and sustainability is foundational to
35 ethically sound short-term global health clinical encounters, so too is identifying and minimizing
36 the burdens such trips place on the host communities.

37
38 Beyond lodging, food, and other direct costs of short-term global health clinical encounters, which
39 are usually reimbursed to host communities [9], such trips can place other, less visible burdens on
40 host communities. Physicians, trainees, and others who organize or participate in short-term global
41 health clinical encounters should be alert to possible unintended consequences that can undermine
42 the value of a trip. Trips should not detract from or place significant burdens on local clinicians and
43 resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt
44 relationships between trainees and their home institutions [9,11]. For example, the expectation that
45 local healthcare and support staff will be available to assist visiting clinicians in addition to (or in
46 place of) their usual duties can disrupt care for their existing patients. It should not be assumed that
47 host communities can absorb additional costs, even on a temporary basis [14]. Particular attention
48 should be paid to the follow-up care that burdens local practitioners and may result in harm to
49 patients in the aftermath of invasive procedures [15].

1 Sharing information beforehand as to how visiting health care professionals are expected to interact
2 with the host community, the team's objectives, and the skill, and training they bring, can reveal
3 potential benefits and harms, thus allowing them to be discussed and addressed before the team
4 embarks on the experience. Likewise, selecting team members whose skills and experience map
5 onto the needs and expectations of the host community can help minimize disruptive effects on
6 local practice [11]. Advance preparation should include developing a plan to monitor and address
7 ongoing costs and benefits to patients, host communities and institutions, including local trainees
8 (when the trip includes providing training for the host community) [11].
9

10 Respecting Persons & Cultures

11
12 Physicians and trainees who participate in short-term global health clinical encounters face a host
13 of challenges. Some of them are practical, such as resource limitations, unfamiliar medical needs,
14 living conditions outside their experience, among many others. Others involve successfully
15 navigating language(s) and norms they may never have encountered before, or not encountered
16 with the same immediacy [1,2,9]. Striking a balance between Western medicine's understanding of
17 professional ethics and the expectations of host communities rooted in other histories, traditions,
18 and social structures calls for a level of discernment, sensitivity, and humility that may more often
19 be seen as the skill set of an ethnographer than a clinician.
20

21 Individuals who travel to provide medical care in under-resourced settings should be aware that the
22 interactions they will have there will inevitably be cross-cultural. They should seek to become
23 broadly knowledgeable about the communities in which they will work, such as the primary
24 language(s) in which encounters will occur; predominant local understandings of health and illness;
25 local expectations for how health care professionals behave toward patients and toward one
26 another; and salient economic, political, and social dynamics. Participants should take advantage of
27 resources that can help them cultivate the cultural sensitivity they will need to provide safe,
28 respectful, patient-centered care in the context of the specific host community [7,10,11]. Further,
29 trip participants should be mindful that they bring with them their own unexamined cultural beliefs
30 and assumptions about under-resourced communities, some of which trace back to colonialist,
31 racialized attitudes. For instance, there is a widespread assumption that visiting physicians and
32 trainees possess universally applicable (and perhaps superior) skills and knowledge simply by
33 virtue of their association with Western medicine [19].
34

35 Individuals do not bear these responsibilities alone. Organizations and institutions that sponsor
36 short-term global health clinical encounters have a responsibility to make appropriate orientation
37 and training available to participants before they depart [11], in addition to working with host
38 communities to put in place appropriate services, such as interpreters or local mentors, to support
39 participants during the experience.
40

41 The ethical obligation to respect the individual patients they serve and their host communities'
42 cultural and social traditions does not obligate physicians and trainees "to violate fundamental
43 personal values, standards of medical care or ethical practice, or the law" [9]. Participants will
44 likely be challenged, rather, to negotiate compromises that preserve in some reasonable measure
45 the values of both parties whenever possible [16]. Participants should be allowed to decline to
46 participate in activities that violate deeply held personal beliefs, but they should reflect carefully
47 before reaching such a decision [17].

1 PREPARATION FOR THE EXPERIENCE

2
3 Fulfilling these fundamental ethical responsibilities requires meeting other obligations with respect
4 to organizing and carrying out short-term global health clinical encounters. Specifically, sponsoring
5 organizations and institutions have an obligation to ensure thoughtful, diligent preparation to
6 promote a trip's overall goals, including appropriately preparing participants for the experience.
7 Physicians and trainees, for their part, have an obligation to thoughtfully choose those programs
8 with which they affiliate themselves [1,2,9,11].
9

10 Prepare Diligently

11
12 Guidelines from the American College of Physicians recognize that “predeparture preparation is
13 itself an ethical obligation” even though this is far from a universal practice at present [9,cf. 2,12].
14 Collaborative planning can identify what material resources and clinical skills participants should
15 be expected to bring to the effort. For example, what activities participants should be assigned, or
16 whether local mentors are needed or desirable and how such relationships will be coordinated [11].
17

18 Supervision of trainees also needs to be explicitly arranged and followed up once they arrive in the
19 host community. Studies show that 20% of participants reported inadequate supervision during
20 their trips, and it is common for medical schools to allow “students to arrange encounters abroad
21 without faculty supervision and support” [18,12]. Allowing students to practice in under-resourced
22 settings without proper supervision is a clear violation of their fiduciary duty.
23

24 Thoughtful preparation includes determining what nonclinical skills and experience participants
25 should have to contribute to the overall success of the experience. For example, the goal of
26 supporting capacity building in the local community calls for participants who have “training
27 and/or familiarity with principles of international development, social determinants of health,
28 ...public health systems” and in some cases, health care administration [10,12]. Without this
29 background, interventions may result in “resource wasting and potentially poorer patient care”
30 [12].
31

32 Adequately preparing physicians and trainees for short-term global health clinical encounters
33 encompasses planning with respect to issues of personal safety, vaccinations, unique personal
34 health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally
35 important, to contribute effectively and minimize “culture shock” and distress, participants need a
36 basic understanding of the context in which they will be working [1,2,7]. Without expecting them
37 to become experts in local culture, participants should have access to resources that will orient
38 them to the language(s), traditions, norms, and expectations of the host community, not simply to
39 the resources and clinical challenges they are likely to face. Participants should have sufficient
40 knowledge to conduct themselves appropriately, whether that is in how they dress, how they
41 address or interact with different members of the community, or how they carry out their clinical
42 responsibilities [7]. They also need to know to whom they can turn for guidance. If at all possible,
43 this should be someone from outside the host community, since community members may be
44 reluctant to “push back” against the judgments and actions of participants [19].
45

46 Preparation should also include explicit attention to the possibility that participants will encounter
47 ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the
48 real possibility that physicians and trainees will encounter situations in which they “are unable to
49 act in ways that are consistent with ethics and their professional values” or “feel complicit in a
50 moral wrong” [9]. In particular, participants will be required to assess “how to balance risks and
51 benefits [for patients who have been economically marginalized and who are experiencing illnesses

1 with which they have little clinical experience] ... how to distribute limited medical resources, and
2 when non-intervention is the appropriate choice” [15]. In addition, participants may find that local
3 beliefs are inconsistent with their own ethical commitments. Having strategies in place to address
4 dilemmas when they arise and to debrief after the fact can help mitigate the impact of such
5 encounters. Physicians under stress due to difficult ethical situations experience emotional harm
6 and this may, in turn, affect the quality of patient care [12]. In cases of irreducible conflict with
7 local norms, participants may withdraw from care of an individual patient or from the project after
8 careful consideration of the effect withdrawing will have on patients, the medical team, and the
9 larger goals of the experience, in keeping with ethics guidance on the exercise of conscience. In
10 addition, participants should keep in mind that some care is not always better than no care, and
11 should ensure that they are able to provide safe, respectful, patient-centered care in the context of
12 the specific host community at all times. This context requires cultural respect and awareness on
13 the part of participants, as well as ongoing attention to the fact that certain treatment decisions may
14 become burdensome to the local medical community once the volunteers leave.

15 16 Choose Thoughtfully

17
18 Individual physicians and trainees who participate in short-term global health clinical encounters
19 are not typically in a position to directly influence how such programs are organized or carried out.
20 They can, however, choose to participate in activities carried out by organizations that fulfill the
21 ethical and professional responsibilities discussed above [9,10,11]. Participants can select
22 organizations and programs that demonstrate commitment to long-term, community-led efforts to
23 build and sustain local health care resources over programs that provide episodic, stop-gap medical
24 interventions [10]. Participants should strive to avoid working with “volunteer placement
25 organizations” that operate primarily for their own profit and/or lack adequate on-site supervision
26 for trainees [14]. Such organizations exploit the needs of host communities by offering them a
27 small sum per participant and then sending participants to them without support. Physicians and
28 trainees should also refrain from the “casual or opportunistic” treatment of patients that are not
29 coordinated with local health care systems in advance [20].

30 31 Measure & Share Meaningful Outcomes

32
33 Organizations that sponsor short-term global health clinical encounters have a responsibility to
34 monitor and evaluate the effectiveness of their programs, and to disseminate their findings in a
35 transparent manner [7,9,10]. The measures used to evaluate program outcomes should be
36 appropriate to the program’s goals as defined proactively in collaboration with the host community
37 [9]. Prospective participants should affiliate themselves with programs that demonstrate
38 effectiveness in providing outcomes meaningful to the population they serve, rather than simple
39 measures of process such as number of procedures performed [7]. Since the success of procedures
40 and programs cannot reasonably be verified if even their medium-term outcomes cannot be
41 monitored, participants should prefer programs that can track patient results over an extended
42 timeframe, even if their own contribution is made in a short time.

43 44 RECOMMENDATION

45
46 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the
47 following be adopted, and the remainder of this report be filed:

48
49 Short-term global health clinical encounters, which send physicians and physicians in training
50 from wealthier communities to provide care in under-resourced settings for a period of days or
51 weeks, have been promoted as a strategy to provide needed care to individual patients and,

1 increasingly, as a means to address global health inequities. To the extent that such encounters
2 also provide training and educational opportunities, they may offer benefit both to the host
3 communities and the medical professionals and trainees who volunteer their time and clinical
4 skills.

5
6 Short-term global health clinical encounters typically take place in contexts of scarce resources
7 and in the shadow of colonial histories. These realities define fundamental ethical
8 responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet
9 mutually agreed-on goals; navigate day-to-day collaboration across differences of culture,
10 language, and history; and fairly allocate resources. Participants and sponsors must focus not
11 only on enabling good health outcomes for individual patients, but on promoting justice and
12 sustainability, minimizing burdens on host communities, and respecting persons and local
13 cultures. Responsibly carrying out short-term global health clinical encounters requires diligent
14 preparation on the part of participants and sponsors in collaboration with host communities.

15
16 Physicians and trainees who are involved with short-term global health clinical encounters
17 should ensure that the trips with which they are associated:

- 18
19 (a) Focus prominently on promoting justice and sustainability by collaborating with the host
20 community to define project parameters, including identifying community needs, project
21 goals, and how the visiting medical team will integrate with local health care professionals
22 and the local health care system. In collaboration with the host community, short-term
23 global health clinical encounters should prioritize efforts to support the community in
24 building health care capacity. Trips that also serve secondary goals, such as providing
25 educational opportunities for trainees, should prioritize benefits as defined by the host
26 community over benefits to members of the visiting medical team or the sponsoring
27 organization.
- 28
29 (b) Seek to proactively identify and minimize burdens the trip places on the host community,
30 including not only direct, material costs of hosting participants, but also possible adverse
31 effects the presence of participants could have for beneficial local practices and local
32 practitioners. Sponsors and participants should ensure that team members practice only
33 within their skill sets and experience.
- 34
35 (c) Provide resources that help them become broadly knowledgeable about the communities in
36 which they will work and to cultivate the cultural sensitivity they will need to provide safe,
37 respectful, patient-centered care in the context of the specific host community. Members of
38 the visiting medical team are expected to uphold the ethics standards of their profession
39 and participants should insist that strategies are in place to address ethical dilemmas as
40 they arise. In cases of irreducible conflict with local norms, participants may withdraw
41 from care of an individual patient or from the project after careful consideration of the
42 effect that will have on the patient, the medical team, and the project overall, in keeping
43 with ethics guidance on the exercise of conscience. Participants should be clear that they
44 may be ethically required to decline requests for treatment that cannot be provided safely
45 and effectively due to resource constraints.
- 46
47 (d) Are organized by sponsors that embrace a mission to promote justice, patient-centered
48 care, community welfare, and professional integrity. Physicians, as influential members of
49 their health care systems, are well positioned to influence the selection, planning and
50 preparation for short term encounters in global health. In addition, they can take key roles
51 in mentoring learners and others on teams to be deployed. Physicians can also offer

1 guidance regarding the evaluation process of the experience, in an effort to enhance and
2 improve the outcomes of future encounters.

3
4 Sponsors of short-term global health clinical encounters should:(e) Ensure that resources
5 needed to meet the defined goals of the trip will be in place, particularly resources that cannot
6 be assured locally. This includes arranging for local mentors, translation services, and
7 participants' personal health needs. It should not be assumed that host communities can absorb
8 additional costs, even on a temporary basis.

9
10 (f) Proactively define appropriate roles and permissible range of practice for members of the
11 visiting medical team, so that they can provide safe, high-quality care in the host
12 community. Team members should practice only within the limits of their training and
13 skills in keeping with professional standards they would deem acceptable in their ordinary
14 clinical practice, even if the host community's standards are more flexible or less
15 rigorously enforced.

16
17 (g) Ensure appropriate supervision of trainees, consistent with their training in their home
18 communities, and make certain that they are only permitted to practice independently in
19 ways commensurate with their level of experience in under-resourced settings.

20
21 (h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized
22 standards for the conduct of health services research and quality improvement activities in
23 the sponsor's country.

24
25 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Bauer I. More harm than good? The questionable ethics of medical volunteering and student placements. *Tropical Diseases, Travel Medicine and Vaccines* 2017;3:5
2. Consortium of Universities for Global Health. Cough.org. Accessed January 10, 2020.
3. Association of American Medical Colleges. *Medical School Graduation Questionnaire 2018 All Schools Summary Report*. Available at: <https://www.aamc.org/system/files/reports/1/2018gqallschoolssummaryreport.pdf>. Accessed October 29, 2019.
4. DeCamp M. Ethical review of global short-term medical volunteerism. *HEC Forum*. 2011;23:91–103.
5. Roche SD, Ketheeswaran P, Wirtz VJ. International short-term medical missions: a systematic review of recommended practices. *Int J Public Health*. 2017;62:31–42.
6. Stone GS, Olson KR. The ethics of medical volunteerism. *Med Clin N Am*. 2016;100:237–246.
7. Sykes KJ. Short-term medical service trips: a systematic review of the evidence. *Am J Public Health*. 2014;104:e38–e48.
8. DeCamp M, Soleymani Lehmann L, Jaell P, et al. Ethical obligations regarding short-term global health clinical experiences: an American College of Physicians position paper. *Ann Intern Med*. 2018;160:651–657.
9. Melby MK, Loh LC, Evert J, et al. Beyond medical “missions” to impact-driven short-term experiences in global health (STEGHs): ethical principles to optimize community benefit and learner experience. *Acad Med*. 2016;91(5):633–638.
10. Keller RC. Geographies of power, legacies of mistrust: colonial medicine in the global present. *Historical Geography* 2006;34:26-48.
11. Snyder J, Dharamsi S, Crook VA. Fly-by medical care: conceptualizing the global social responsibilities of medical tourisms and physician voluntourists. *Globalization and Health* 2011;7:6.
12. Asgary, R and Junck, E. New trends of short-term humanitarian medical volunteerism: professional and ethical considerations. *J Med Ethics*. 2013;39:625–31.
13. Crump JA, Sugarman J. Global health training: ethics and best practice guidelines for training experiences in global health. *Am J Trop Med Hyg*. 2010;83(6):1178–118
14. Nouvet E, Chan E, Schwartz L. Looking good but doing harm? perceptions of short-term medical missions in Nicaragua. *Glob Public Health*. 2018;13(4):456–72.
15. Wall, A. The Context of Ethical Problems in Medical Volunteer Work. *HEC Forum*. 2011;23:79–90.
16. Freedman B. Offering truth: one ethical approach to the uninformed cancer patient. *Arch Intern Med*. 1983;153:572–576.
17. American Medical Association. *Code of Medical Ethics*, Opinion 1.1.7, Physician exercise of conscience. Available at <https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience>. Accessed October 29, 2019.
18. Doobay-Persaud A, Evert J, DeCamp M et al. Extent, nature and consequences of performing outside scope of training in global health. *Glob. Health*. 2019; 15: 1-16.
19. Sullivan N. International clinical volunteering in Tanzania: A postcolonial analysis of global health business. *Glob Public Health*. 2018;13(3):310–24.
20. Bishop, Rachel and Litch, James. Medical tourism can do harm. *BMJ*. 2000;320.

REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)
Research Handling of De-Identified Patient Data
(D-315.969)

EXECUTIVE SUMMARY

In adopting policy D-315.969, “Research Handling of De-Identified Patient Data,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and the risks of re-identification.

This report articulates a series of recommendations on how best to respond to the increasing collection, sale, and use of de-identified patient data and the associated risks. The report outlines how health data exist within digital information ecosystems, how such complex ecosystems pose challenges to data privacy, how de-identified data functions as a public good for clinical research, and how de-identified data derived within the context of health care institutions lead to certain ethical standards for and protections of that data.

Because CEJA recognizes both the promise of de-identified datasets for advancing health and the concerns surrounding the use of de-identified patient data including the risks of re-identification that extend from the level of individual physicians collecting clinical data to hospitals and other health care institutions as repositories and stewards of data, this report proposes a new Code of Medical Ethics opinion be adopted in conjunction with amendments to four existing opinions to provide ethics guidance in this rapidly evolving digital health ecosystem.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-24

Subject: Research Handling of De-Identified Patient Data
(D-315.969)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy [D-315.969](#), “Research Handling of De-Identified Patient Data,” adopted by the American
2 Medical Association (AMA) House of Delegates in November 2021, asked the Council on Ethical
3 and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and
4 the risks of re-identification.

5
6 In its informational report on de-identified data [[CEJA 6-A-23](#)], CEJA examined a range of
7 challenges that health care professionals and institutions are now confronted with as technological
8 innovations rapidly evolve both within and outside of health care, blurring the boundary
9 distinctions between these spheres. CEJA’s exploration suggested that in this dynamic environment,
10 foundational ethical concepts of privacy and consent likely need to be revisited to better reflect that
11 personal health information today exists in digital environments where responsibilities are
12 distributed among multiple stakeholders.

13
14 This report expands on the previous work to articulate a series of recommendations on how best to
15 respond to the increasing collection, sale, and use of de-identified patient data and the associated
16 risks. The report outlines how health data exist within digital information ecosystems, how such
17 ecosystems pose challenges to data privacy, what the *Code* says about data privacy and informed
18 consent, how de-identified data functions as a public good for clinical research, how privacy
19 scholars are reconceptualizing privacy as contextual integrity, and how de-identified data derived
20 within the context of health care institutions lead to certain ethical standards for and protections of
21 that data.

22
23 Because CEJA recognizes both the promise of de-identified datasets for advancing health and the
24 concerns surrounding the use of de-identified patient data including the risks of re-identification
25 that extend from the level of individual physicians collecting clinical data to hospitals and other
26 health care institutions as repositories and stewards of data, this report proposes a new ethics
27 opinion in conjunction with amendments to four existing opinions to provide ethics guidance in
28 this rapidly evolving digital health ecosystem.

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

1 HEALTH DATA & DIGITAL ECOSYSTEMS

2
3 De-identified patient data are a subset of health data that exists within larger digital health
4 information ecosystems [1]. Such ecosystems are highly dynamic and distributed, with health
5 information often being combined from multiple datasets and distributed among multiple
6 stakeholders [1]. Traditionally, health data has referred to patient health information produced from
7 patient–physician interactions and stored by health care organizations [2]. This type of data is
8 typically recorded as identifiable patient data and entered into the patient’s electronic medical
9 record (EMR); from there, it can be de-identified and bundled together with other patient data to
10 form an aggregated dataset. In the age of Big Data, however, where large datasets can reveal
11 complex patterns and trends, diverse sets of information are increasingly brought together. Health
12 data now extends to all health-relevant data, including data collected anywhere from individuals
13 both passively and actively that can reveal information about health and health care use [2].

14
15 Within digital health ecosystems, health-related data can be generated by health care systems (e.g.,
16 EMRs, prescriptions, laboratory data, radiology), the consumer health and wellness industry (e.g.,
17 wearable fitness tracking devices, wearable medical devices such as insulin pumps, home DNA
18 tests), digital exhaust from daily digital activities (e.g., social media posts, internet search histories,
19 location and proximity data), as well as non-health sources of data (e.g., non-medical records of
20 race, gender, education level, residential zip code, credit history) [2]. The ethical challenges raised
21 by such widely distributed data ecosystems, with their vast array of data types and multiple
22 stakeholders, require a holistic approach to the moral issues caused by digital innovation. Digital
23 ethics has arisen as a theoretical framework to analyze these recent challenges and examine such
24 ethical concerns from multiple levels of abstraction. The digital ethics framework takes into
25 account the general environment in which ethical concerns arise and examines ethical dilemmas as
26 they relate to information and data, algorithms, practices and infrastructure, and their impact on the
27 digital world [3].

28 29 CHALLENGES TO DATA PRIVACY

30
31 In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints
32 on the sharing of “protected health information,” including individually identifiable health
33 information contained in the EMR, by “covered entities,” including physicians, hospitals,
34 pharmacies, and third-party payers. HIPAA’s scope is narrow and does not cover other health-
35 relevant data, such as data generated voluntarily by patients themselves, for example, through the
36 use of commercial health-related apps or devices, or identifiable data individuals provide to
37 municipal authorities, utilities, retailers, or on social media. Furthermore, information that began in
38 the medical record can take on a new, independent life when linked with personal information
39 widely available through datasets generated outside of health care. As McGraw and Mandl explain,
40 “since HIPAA’s coverage is about ‘who’ holds the data, but not what type of data, much of the
41 health-relevant data collected today are collected by entities outside of HIPAA’s coverage bubble
42 and thus resides outside of HIPAA’s protections” [2]. HIPAA is thus limited in its ability to protect
43 patient data within digital health information ecosystems.

44
45 Complicating the matter is the fact that once patient health data has been de-identified, it is no
46 longer protected by HIPAA, and can be freely bought, sold, and combined with other datasets.
47 Hospitals now frequently sell de-identified datasets to researchers and industry. Recent
48 developments in AI and its use within health care have similarly created new difficulties.

49
50 Patients, and patient privacy advocates, are often concerned about who has access to their data. As
51 data ecosystems have grown larger and more distributed, this has become increasingly more

1 difficult to ascertain. In the age of Big Data, the global sale of data has become a multibillion-
2 dollar industry, with individuals' data viewed by industry as "new oil" [1]. The global health care
3 data monetization market alone was valued at just over \$0.4 billion in 2022 and is expected to grow
4 to \$1.3 billion by 2030 [4]. Industry often purchases hospital datasets to improve marketing and
5 sales, predict consumer behaviors, and to resell to other entities. Within health care and research
6 settings, the massive datasets collected from clinical data—used initially in the care and treatment
7 of individual patients—have created the potential for secondary use as a means for quality
8 improvement and innovation that can be used for the benefit of future patients and patient
9 populations [5].

10
11 The dynamic and distributed nature of today's digital health information ecosystems challenges the
12 prevailing procedural model for protecting patient privacy: informed consent and de-identification.
13 In a world where the secondary use of patient data within large datasets can easily enter into a
14 global marketplace, the intended use is almost impossible to discern. Patients cannot be honestly
15 and accurately informed about the specific terms of interactions between their collected data and
16 the data collector and any potential risks that may emerge [1,6]. Therefore, patients are unable to
17 truly give informed consent. Furthermore, whether de-identifying datasets truly prevents individual
18 data subjects from being re-identified has been increasingly called into question. Removing the 18
19 identifiers specified in HIPAA does not ensure that the data subject cannot be re-identified by
20 triangulation with identifying information from other readily available datasets [7]. Machine
21 learning and AI technologies have advanced to the point that virtually all de-identified datasets risk
22 re-identification, such that "even when individuals are not 'identifiable', they may still be
23 'reachable'" [6].

24
25 A final avenue to consider with respect to private health information and patient privacy is the risk
26 of health care data breaches. Raghupathi et al note, "[h]ealthcare is a lucrative target for hackers.
27 As a result, the healthcare industry is suffering from massive data breaches" [8]. The number of
28 health care data breaches continues to increase every year, exposing the private health information
29 of millions of Americans. Despite being heavily targeted by cybercriminals, health care providing
30 institutions are widely considered by cybersecurity experts to lack sufficient security safeguards
31 [8]. Raghupathi et al note, "healthcare entities gathering and storing individual health data have a
32 fiduciary and regulatory duty to protect such data and, therefore, need to be proactive in
33 understanding the nature and dimensions of health data breaches" [8].

34 35 CLINICAL DATA AND PRIVACY

36
37 Within the *Code*, [Opinion 3.1.1](#), "Privacy in Health Care," distinguishes four aspects of privacy:

38
39 personal space (physical privacy), personal data (informational privacy), personal choices
40 including cultural and religious affiliations (decisional privacy), and personal relationships with
41 family members and other intimates (associational privacy).

42
43 The *Code* does not explicitly examine whether personal medical or health information are ethically
44 distinct from other kinds of personal information (e.g., financial records) or in what way. Current
45 guidance treats the importance of protecting privacy in all its forms as self-evident, holding that
46 respecting privacy in all its aspects is of fundamental importance, "an expression of respect for
47 autonomy and a prerequisite for trust" [Opinion 3.1.1]. However, [Opinion 3.3.3](#), "Breach of
48 Security in Electronic Medical Records," directly acknowledges that data security breaches create
49 potential "physical, emotional, and dignity harms" to patients. Similarly, [Opinion 7.3.7](#),
50 "Safeguards in the Use of DNA Databanks," states that breaches of confidential patient information

1 “may result in discrimination or stigmatization and may carry implications for important personal
2 choices.”

3
4 Violations of privacy can result in both harm—tangible negative consequences, such as
5 discrimination in insurance or employment or identity theft—and in wrongs that occur from the
6 fact of personal information being known without the subject’s awareness, even if the subject
7 suffers no tangible harm [7]. Price and Cohen note that privacy issues can arise not only when data
8 are known, but when data mining enables others to “generate knowledge about individuals through
9 the process of inference rather than direct observation or access” [7].

10 11 CLINICAL DATA AND INFORMED CONSENT

12
13 With respect to [Opinion 2.1.1](#), “Informed Consent,” in the *Code*, successful communication is seen
14 as essential to fostering trust that is fundamental to the patient–physician relationship and to
15 supporting shared decision making. Opinion 2.1.1 states: “[t]he process of informed consent occurs
16 when communication between a patient and physician results in the patient’s authorization or
17 agreement to undergo a specific medical intervention.” In seeking a patient’s informed consent,
18 physicians are directed to include information about “the burdens, risks, and expected benefits of
19 all options, including forgoing treatment” [Opinion 2.1.1]. It should be noted, however, that no
20 direct mention of patient data is discussed in the opinion, other than that documentation of consent
21 should be recorded in the patient’s medical record.

22 23 CLINICAL DATA, DATASETS, AND THE PUBLIC GOOD

24
25 Because aggregated clinical data has the potential for secondary use that can benefit all of society,
26 it has been argued that such data should be treated as a form of public good [5]. When clinical data
27 are de-identified and aggregated, the potential use for societal benefits through research and
28 development is an emergent, secondary side effect of electronic health records that goes beyond
29 individual benefit. Larson et al argue that not only does the public possess an interest in
30 safeguarding and promoting clinical data for societal benefits, but all those who participate in
31 health care systems have an ethical responsibility to treat such data as a form of public good [5].
32 They propose:

33
34 all individuals and entities with access to clinical data inherently take on the same fiduciary
35 obligations as those of medical professionals, including for-profit entities. For example, those
36 who are granted access to the data must accept responsibility for safeguarding protected health
37 information [5].

38
39 This entails that any entity that purchases private health information, whether or not it has been de-
40 identified, has an ethical obligation to adhere to the ethical standards of health care where such data
41 were produced. Hospitals thus have an ethical responsibility to ensure that their contracts of sale
42 for datasets insist that all entities that gain access to the data adhere to the ethical standards and
43 values of the health care industry.

44
45 This is particularly important when we recall that the wide distribution of digital health information
46 ecosystems increasingly includes non-health-related parties from industry that may have market
47 interests that conflict with the ethical obligations that follow health data. Within this framework,
48 the fiduciary duty to protect patient privacy as well as to society to improve future health care
49 follows the data and thus applies to all entities that use that data, such that all entities granted
50 access to the data become data stewards, including for-profit parties [5]. This also includes patients,
51 such that they bear a responsibility to allow their data to be used for the future improvement of

1 health care for society, especially when we recognize that current health care has already benefited
2 from past data collection [5].

3
4 While the re-identification of aggregated patient data should generally be prohibited, there are rare
5 exceptions. There may be occasions when researchers wish to re-identify a dataset, such as
6 sometimes occurs in the study of rare diseases that rely on international registries; in such
7 situations, all individuals must be re-contacted, and their consent obtained in order to re-identify
8 their data since this would represent a significant change to the initial research protocols and
9 respective risks [9]. Re-identification of datasets for research is uncommon, however, because
10 obtaining re-consent can be difficult and can lead to flawed research if data is lost because patients
11 do not re-consent. The other situation in which it may be permissible, or even obligatory, to re-
12 identify aggregated patient data is when doing so would be in the interest of the health of individual
13 patients, such as might occur in the study of a rare genetic disorder. Even within these exceptions,
14 the risks associated with re-identification remain and re-identified data should thus never be
15 published. Re-identification of de-identified patient data for any other purposes, by anyone inside
16 or outside of health care, must be avoided.

17 18 AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

19
20 Within today's digital health information ecosystems, physicians and hospitals face several
21 challenges to protecting patient privacy. Barocas and Nissenbaum contend that "even if [prevailing
22 forms of consent and anonymization] were achievable, they would be ineffective against the novel
23 threats to privacy posed by big data" [6]. A more effective option, Nissenbaum has argued, would
24 understand privacy protection as a function of "contextual integrity," i.e., that in a given social
25 domain, information flows conform to the context-specific informational norms of that domain.
26 Whether a transmission of information is appropriate depends on "the type of information in
27 question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints
28 under which this transmission takes place" [10]. The view of privacy as contextual integrity—that
29 our conception of privacy is contextual and governed by various norms of information flow—
30 recognizes that there exist different norms regarding privacy within different spheres of any
31 distributed digital ecosystem [7,11]. The challenge within health care, as we have seen, is how to
32 balance these various norms when they conflict and how to ensure that health care's ethical
33 standards and values are maintained throughout the distributed use of de-identified private health
34 information.

35 36 THE CONTEXTUAL INTEGRITY OF DE-IDENTIFIED HEALTH DATA

37
38 In handling patient data, individual physicians strive to balance supporting and respecting patient
39 privacy while also upholding ethical obligations to the betterment of public health. Through their
40 own actions, as well as through their membership organizations and through their health care
41 organizations, physicians should: (1) ensure that data entered into electronic records are accurate
42 and reliable to the best of their ability; (2) be transparent with patients regarding the limited extent
43 to which their data can be safely protected, how their data may be used, and why the use of such
44 data is crucial for improving health care outcomes within society; and (3) ensure that proper
45 oversight and protections of data are in place, including contractual provisions that any data sold or
46 shared with outside entities stay in alignment with the ethical standards of the medical profession,
47 and that meaningful sanctions or penalties are in place and enforced against any actors that violate
48 those ethical standards. It is critical to recognize, as is outlined in the *Code*, that the patient-
49 physician relationship is built on trust, and that this trust relies heavily on transparency.

1 It is important for both patient care and research that clinical data entered into the EMR be as
2 accurate and complete as possible. Some data capture practices, such as copying-and-pasting daily
3 progress notes from previous encounters, which may contribute to efficiency, can lead to
4 documentation errors [12]. One avenue for improving EMR accuracy is that, under HIPAA,
5 patients have the right to access their data and request any perceived errors be amended. While
6 there is no one solution to improving accuracy of EMR data, further study into how to improve
7 EMR accuracy is important. One challenge to both EMR accuracy and completeness is the limited
8 interoperability of different EMR systems. Matching digital health records for the same patient
9 across and within health care facilities can be a challenge, further contributing to the potential for
10 EMR errors. Standardization of recording data elements, such as capturing patient address and last
11 name in a consistent format, may improve matching of patient records and thus improve the
12 accuracy of the EMR [13].

13
14 Another challenge to EMR data quality is the risk of bias, primarily due to implicit bias in EMR
15 design and underrepresentation of patients from historically marginalized groups, low
16 socioeconomic status, and rural areas [14,15]. Critically important for research involving data
17 collected from EMRs, available EMR data only reflects those with access to health care in the first
18 place. While certain study designs and tools have been developed to reduce these biases in
19 research, physicians and health care institutions should be looking into ways to reduce bias within
20 EMRs, such as features to optimize effective EMR use and to consistently capture patient data,
21 especially data on race/ethnicity and social determinants of health that are often inconsistently and
22 inaccurately captured in EMR systems [14,15,16].

23
24 Patients have a right to know how and why their data are being used. While physicians should be
25 able to answer questions regarding patient data as they relate to HIPAA protections, it is the
26 responsibility of health care institutions to provide more detailed information regarding
27 expectations of data privacy, how patient data may be used, and why such use is important to
28 improve the future of health care. Health care systems may consider fulfilling this ethical
29 obligation by creating a patient notification of data use built into the patient registration process
30 (using language similar to the National Institutes of Health's (NIH) Introduction-Description
31 component, meant to provide prospective research participants with an introduction to and
32 description of the planned storage and sharing of data and biospecimens [17]).

33
34 As stewards of health data, health care institutions have an ethical responsibility to protect data
35 privacy. This fiduciary duty to patient data should be seen as following the data even after they are
36 de-identified and leave the institution where they were initially captured [5,8]. While hospitals and
37 health care organizations increasingly come under cyberattack, they consistently lag behind other
38 industries in cybersecurity [18]. With regards to protecting the data they maintain, health care
39 institutions have a responsibility to make more significant investments in cybersecurity.

40
41 In order to ensure that the ethical standards of health care are maintained even after data leaves
42 health care institutions, McGraw and Mandl propose that companies collecting or using health-
43 relevant data could be required to establish independent data ethics review boards [2]. They write
44 that such boards could be similar to Institutional Review Boards but should focus more on privacy
45 than on participant risk, evaluating proposed data projects for legal and ethical implications as well
46 as their potential to improve health and/or the health care system [2]. In practice, ethics review
47 boards involved with industry face challenges to both independence and efficacy. Independence
48 can be compromised by influences such as conflicts of interest, while efficacy can be compromised
49 by the absence of authority, procedures, and systems to enact recommendations made by these
50 review bodies. To be effective, data ethics review boards must be independent and free of conflicts
51 of interest from the company or organization whose data research proposal(s) they are evaluating

1 and have systems in place for both transparency and implementation of feedback for remediations
2 of privacy and other quality and ethics concerns. Though not a comprehensive solution,
3 independent data ethics review boards could be an effective safeguard against industry conflicts of
4 interest and should be considered as a required part of contracts of sale of health data, with
5 contracts stipulating that any future resale of the data also undergo review by a data ethics review
6 board.

7
8 An additional safeguard is the implementation of regular data audits to assess the quality and use of
9 shared data [19]. These regulatory measures could be implemented as requirements outlined in
10 Data Use Agreements or Data Sharing Agreements (DSAs). Such agreements have the potential to
11 establish data governance policies and practices within health care institutions regarding “what data
12 can be shared, with whom, under what conditions, and for what purposes.” In developing DSAs,
13 hospital administrators should engage all relevant stakeholders, require a neutral entity be
14 designated as an independent custodian of shared data, limit the types and/or characteristics of
15 shared data to certain purposes, and apply additional safeguards to protect the data [20].

16
17 The need for more transparent disclosure to patients regarding their data use as well as the
18 importance of building the values of medical ethics into the contracts of sale of aggregate datasets
19 created by hospitals highlights the fact that the ethical responsibilities to respond to the risks of de-
20 identified data should not be borne by physicians alone. Respecting patient privacy and their
21 informed consent are responsibilities that physician member organizations and health care
22 institutions must take on because the risks to these rights that patients face within digital health
23 ecosystems radiate far beyond the patient–physician relationship to areas where individual
24 physicians have little influence.

25 26 RECOMMENDATIONS

27
28 In light of the challenges considered with regard to constructing a framework for holding
29 stakeholders accountable within digital health information ecosystems, the Council on Ethical and
30 Judicial Affairs recommends:

31 32 1. That the following be adopted:

33
34 Within health care systems, identifiable private health information, initially derived from and
35 used in the care and treatment of individual patients, has led to the creation of massive de-
36 identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a
37 means for quality improvement and innovation that can be used for the benefit of future
38 patients and patient populations. While de-identification of data is meant to protect the privacy
39 of patients, there remains a risk of re-identification, so while patient anonymity can be
40 safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive
41 to balance supporting and respecting patient privacy while also upholding ethical obligations to
42 the betterment of public health.

43
44 When clinical data are de-identified and aggregated, their potential use for societal benefits
45 through research and development is an emergent, secondary use of electronic health records
46 that goes beyond individual benefit. Such data, due to their potential to benefit public health,
47 should thus be treated as a form of public good, and the ethical standards and values of health
48 care should follow the data and be upheld and maintained even if the data are sold to entities
49 outside of health care. The medical profession’s responsibility to protect patient privacy as well
50 as to society to improve future health care should be recognized as inherently tied to these

1 datasets, such that all entities granted access to the data become data stewards with a duty to
2 uphold the ethical values of health care in which the data were produced.

3
4 As individuals or members of health care institutions, physicians should:

- 5
6 (a) Follow existing and emerging regulatory safety measures to protect patient privacy;
7
8 (b) Practice good data intake, including collecting patient data equitably to reduce bias in
9 datasets;
10
11 (c) Answer any patient questions about data use in an honest and transparent manner to the
12 best of their ability in accordance with current federal and state legal standards.

13
14 Health care entities, in interacting with patients, should adopt policies and practices that
15 provide patients with transparent information regarding:

- 16
17 (d) The high value that health care institutions place on protecting patient data;
18
19 (e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of
20 re-identification does exist;
21
22 (f) How patient data may be used;
23
24 (g) The importance of de-identified aggregated data for improving the care of future patients.

25
26 Health care entities managing de-identified datasets, as health data stewards, should:

- 27
28 (h) Ensure appropriate data collection methods and practices that meet industry standards to
29 support the creation of high-quality datasets;
30
31 (i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing
32 Agreements for the use of de-identified datasets that may be shared, sold, or resold;
33
34 (j) Develop models for the ethical use of de-identified datasets when such provisions do not
35 exist, such as establishing and contractually requiring independent data ethics review
36 boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and
37 potential resale of clinically-derived datasets;
38
39 (k) Take appropriate cyber security measures to seek to ensure the highest level of protection is
40 provided to patients and patient data;
41
42 (l) Develop proactive post-compromise planning strategies for use in the event of a data
43 breach to minimize additional harm to patients;
44
45 (m) Advocate that health- and non-health entities using any health data adopt the strongest
46 protections and seek to uphold the ethical values of the medical profession.

47
48 There is an inherent tension between the potential benefits and burdens of de-identified
49 datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-
50 identification of data may be permissible, or even obligatory, in rare circumstances when done
51 in the interest of the health of individual patients. Re-identification of aggregated patient data

1 for other purposes without obtaining patients' express consent, by anyone outside or inside of
2 health care, is impermissible. (New HOD/CEJA Policy); and
3

4 2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion
5 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2,
6 "Confidentiality and Electronic Medical Records" be amended by addition as follows:
7

8 a. Opinion 2.1.1, Informed Consent
9

10 Informed consent to medical treatment is fundamental in both ethics and law. Patients have the
11 right to receive information and ask questions about recommended treatments so that they can
12 make well-considered decisions about care. Successful communication in the patient-physician
13 relationship fosters trust and supports shared decision making. Transparency with patients
14 regarding all medically appropriate options of treatment is critical to fostering trust and should
15 extend to any discussions regarding who has access to patients' health data and how data may
16 be used.
17

18 The process of informed consent occurs when communication between a patient and physician
19 results in the patient's authorization or agreement to undergo a specific medical intervention. In
20 seeking a patient's informed consent (or the consent of the patient's surrogate if the patient
21 lacks decision-making capacity or declines to participate in making decisions), physicians
22 should:
23

- 24 (a) Assess the patient's ability to understand relevant medical information and the implications
25 of treatment alternatives and to make an independent, voluntary decision.
26
27 (b) Present relevant information accurately and sensitively, in keeping with the patient's
28 preferences for receiving medical information. The physician should include information
29 about:
30
31 (i) the diagnosis (when known);
32
33 (ii) the nature and purpose of recommended interventions;
34
35 (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
36
37 (c) Document the informed consent conversation and the patient's (or surrogate's) decision in
38 the medical record in some manner. When the patient/surrogate has provided specific
39 written consent, the consent form should be included in the record.
40

41 In emergencies, when a decision must be made urgently, the patient is not able to participate in
42 decision making, and the patient's surrogate is not available, physicians may initiate treatment
43 without prior informed consent. In such situations, the physician should inform the
44 patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in
45 keeping with these guidelines. (Modify HOD/CEJA Policy)
46

47 b. Opinion 3.1.1, Privacy in Health Care
48

49 Protecting information gathered in association with the care of the patient is a core value in
50 health care. However, respecting patient privacy in other forms is also fundamental, as an
51 expression of respect for patient autonomy and a prerequisite for trust.

1 Patient privacy encompasses a number of aspects, including personal space (physical privacy),
2 personal data (informational privacy), personal choices including cultural and religious
3 affiliations (decisional privacy), and personal relationships with family members and other
4 intimates (associational privacy).

5
6 Physicians must seek to protect patient privacy in all settings to the greatest extent possible and
7 should:

- 8
9 (a) Minimize intrusion on privacy when the patient's privacy must be balanced against other
10 factors.
11
12 (b) Inform the patient when there has been a significant infringement on privacy of which the
13 patient would otherwise not be aware.
14
15 (c) Be mindful that individual patients may have special concerns about privacy in any or all
16 of these areas.
17
18 (d) Be transparent with any inquiry about existing privacy safeguards for patient data but
19 acknowledge that anonymity cannot be guaranteed and that breaches can occur
20 notwithstanding best data safety practices. (Modify HOD/CEJA Policy)
21

22 c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies
23

24 Information contained in patients' medical records about physicians' prescribing practices or
25 other treatment decisions can serve many valuable purposes, such as improving quality of care.
26 However, ethical concerns arise when access to such information is sought for marketing
27 purposes on behalf of commercial entities that have financial interests in physicians' treatment
28 recommendations, such as pharmaceutical or medical device companies.

29
30 Information gathered and recorded in association with the care of a patient is confidential.
31 Patients are entitled to expect that the sensitive personal information they divulge will be used
32 solely to enable their physician to most effectively provide needed services. Disclosing
33 information to third parties for commercial purposes without consent undermines trust, violates
34 principles of informed consent and confidentiality, and may harm the integrity of the patient-
35 physician relationship.

36
37 Physicians who propose to permit third-party access to specific patient information for
38 commercial purposes should:

- 39
40 (a) Only provide data that has been de-identified.
41
42 (b) Fully inform each patient whose record would be involved (or the patient's authorized
43 surrogate when the individual lacks decision-making capacity) about the purpose(s) for
44 which access would be granted.
45

46 Physicians who propose to permit third parties to access the patient's full medical record
47 should:

- 48
49 (c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's
50 medical record.

1 (d) Prohibit access to or decline to provide information from individual medical records for
2 which consent has not been given.

3
4 (e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics
5 guidance.

6
7 Because de-identified datasets are derived from patient data as a secondary source of data for
8 the public good, health care professionals and/or institutions who propose to permit third-party
9 access to such information have a responsibility to establish that any use of data derived from
10 health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA
11 Policy)

12
13 d. Opinion 3.3.2, Confidentiality and Electronic Medical Records

14
15 Information gathered and recorded in association with the care of a patient is confidential,
16 regardless of the form in which it is collected or stored.

17
18 Physicians who collect or store patient information electronically, whether on stand-alone
19 systems in their own practice or through contracts with service providers, must:

20
21 (a) Choose a system that conforms to acceptable industry practices and standards with respect
22 to:

23
24 (i) restriction of data entry and access to authorized personnel;

25
26 (ii) capacity to routinely monitor/audit access to records;

27
28 (iii) measures to ensure data security and integrity; and

29
30 (iv) policies and practices to address record retrieval, data sharing, third-party access and
31 release of information, and disposition of records (when outdated or on termination of
32 the service relationship) in keeping with ethics guidance.

33
34 (b) Describe how the confidentiality and integrity of information is protected if the patient
35 requests.

36
37 (c) Release patient information only in keeping with ethics guidance for confidentiality and
38 privacy. (Modify HOD/CEJA Policy); and

39
40 3. That the remainder of this report be filed.

Fiscal Note: Less than \$500

REFERENCES

1. Ruotsalainen P, Blobel B. Health information systems in the digital health ecosystem—problems and solutions for ethics, trust and privacy. *Int J of Envir Res and Pub health* 2020;17(9):3006.
2. McGraw D, Mandl KD. Privacy protections to encourage use of health-relevant digital data in a learning health system. *NPJ dig med* 2021;4(1):2.
3. Floridi L, Cath C, Taddeo M. Digital ethics: its nature and scope. *The 2018 yearbook of the digital ethics lab* 2019:9-17.
4. Data monetization in healthcare market size report, 2030. In: *Data Monetization In Healthcare Market Size Report, 2030*. <https://www.grandviewresearch.com/industry-analysis/data-monetization-healthcare-market-report>.
5. Larson DB, Magnus DC, Lungren MP, Shah NH, Langlotz CP. Ethics of using and sharing clinical imaging data for artificial intelligence: a proposed framework. *Radiology* 2020;295(3):675-82.
6. Barocas S, Nissenbaum H. Big data's end run around anonymity and consent. *Privacy, big data, and the public good: Frameworks for engagement* 2014;1:44-75.
7. Price WN II, Cohen IG. Privacy in the age of medical big data. *Nat Med* 2019;25:37–43.
8. Raghupathi W, Raghupathi V, Saharia A. Analyzing Health Data Breaches: A Visual Analytics Approach. *AppliedMath* 2023;3(1):175-99.
9. Hansson MG, Lochmüller H, Riess O, Schaefer F, Orth M, Rubinstein Y, Molster C, Dawkins H, Taruscio D, Posada M, Woods S. The risk of re-identification versus the need to identify individuals in rare disease research. *Eur J Hum Genet* 2016;24(11):1553-1558. doi:10.1038/ejhg.2016.52.
10. Nissenbaum, H. Respecting context to protect privacy: why meaning matters. *Sci Eng Ethics* 2018;24:831–52.
11. Nissenbaum H. Privacy as contextual integrity. *Wash. L. Rev* 2004;79:119-158.
12. Weng CY. Data Accuracy in Electronic Medical Record Documentation. *JAMA Ophthalmol* 2017;135(3):232–233. doi:10.1001/jamaophthalmol.2016.5562
13. Pew. Enhancing patient matching is critical to achieving full promise of digital health records: Accurately linking individuals with their health records essential to improving care. *Pew Trust Report* October 2, 2018. <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records>
14. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Equity and bias in electronic health records data. *Contemp Clinic Trials* 2023;130:107238.
15. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Potential bias and lack of generalizability in electronic health record data: reflections on health equity from the National Institutes of Health Pragmatic Trials Collaboratory. *J of the Am Medl Informat Ass* 2023:ocad115.
16. Khurshid S, Reeder C, Harrington LX, Singh P, Sarma G, Friedman SF, Di Achille P, Diamant N, Cunningham JW, Turner AC, Lau ES. Cohort design and natural language processing to reduce bias in electronic health records research. *NPJ Digital Med* 2022;5(1):47.
17. NIH. Informed consent for secondary research with data and biospecimens: Points to consider and sample language for future use and/or sharing. *NIH Office of Science Policy Office of Extramural Research* May 2020. <https://osp.od.nih.gov/wp-content/uploads/Informed-Consent-Resource-for-Secondary-Research-with-Data-and-Biospecimens.pdf>
18. Skahill E, West DM. Why hospitals and healthcare organizations need to take cybersecurity more seriously. *Brookings* August 9, 2021. <https://www.brookings.edu/articles/why-hospitals-and-healthcare-organizations-need-to-take-cybersecurity-more-seriously/>

19. Winter JS, Davidson E. Big Data Governance of personal health information and challenges to Contextual Integrity. *The Information Society* 35:36–51. doi: 10.1080/01972243.2018.1542648
20. Allen C, Des Jardins TR, Heider A, et al. Data Governance and data sharing agreements for community-wide health information exchange: Lessons from the Beacon Communities. *eGEMs (Generating Evidence & Methods to improve patient outcomes)* 2:5. doi: 10.13063/2327-9214.1057

REPORT 3 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)
Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
(D-140.951)

EXECUTIVE SUMMARY

In adopting policy D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to “study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership”.

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. While not inherently unethical, private equity firms’ incursion into health care warrants caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, “Contracts to Deliver Health Care Services” to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-24

Subject: Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
(D-140.951)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 In response to [Policy D-140.951](#), “Establishing Ethical Principles for Physicians Involved in
2 Private Equity Owned Practices,” which instructs our American Medical Association (AMA) to
3 “study and clarify the ethical challenges and considerations regarding physician professionalism
4 raised by the advent and expansion of private equity ownership”, your Council on Ethical and
5 Judicial Affairs (CEJA) presented Report 02-A-23, which offered recommendations on amending
6 [Code Opinion 11.2.3](#), “Contracts to Deliver Health Care Services.” Testimony at the 2023 Annual
7 Meeting of the House of Delegates was predominantly in opposition to the report; concerns were
8 raised regarding the profit motives of private equity and the ethical implications of such
9 businesses’ involvement in health care. Overall, testimony expressed a desire that a stronger stance
10 be taken against private equity’s involvement in health care, and the report was referred back to
11 CEJA.

12

13 BACKGROUND

14

15 The past several decades have seen an increase in the corporatization, financialization, and
16 commercialization of health care [1,2]. Since 2018, more physicians now work as employees of
17 hospitals or health care systems rather than serving in private practice [3,4]. Our AMA reports that
18 this trend is continuing: “[e]mployed physicians were 50.2% of all patient care physicians in 2020,
19 up from 47.4% in 2018 and 41.8% in 2012. In contrast, self-employed physicians were 44% of all
20 patient care physicians in 2020, down from 45.9% in 2018 and 53.2% in 2012” [4]. A major factor
21 in these trends has been the incursion of private equity into health care. It is estimated that private
22 equity capital investment between 2000 and 2018 grew from \$5 billion to \$100 billion [1].
23 Between 2016 and 2017 alone, the global value of private equity deals in health care increased
24 17%, with health care deals comprising 18% of all private equity deals in 2017 [5].
25

26

27 Private equity firms use capital from institutional investors to purchase private practices, typically
28 utilizing a leveraged buy-out model that finances the majority of the purchase through loans for
29 which the physician practice serves as security, with the goal of selling the investment within 3 to 7
30 years and yielding a return of 20-30% [1,5,6]. However, private equity investment broadly
31 encompasses many types of investors and strategies, including venture capital firms that primarily
invest in early-stage companies for a minority ownership, growth equity firms that tend to partner

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

1 with promising later-stage ventures, and traditional private equity firms that borrow money through
2 a leveraged buyout to take a controlling stake of mature companies [7].

3
4 When ownership shifts from physicians to private equity firms, the firms typically seek to invest
5 resources to expand market share, increase revenue, and decrease costs to make the practice more
6 profitable before selling it to a large health care system, insurance company, another private equity
7 firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand
8 market share, private equity typically employs a “platform and add-on” or “roll-up” approach in
9 which smaller add-ons are acquired after the initial purchase of a large, established practice,
10 allowing private equity firms to gain market power in a specific health care segment or sub-
11 segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions
12 within health care, significantly contributing to the consolidation of the health care industry that
13 has dramatically increased over the past decade [9].

14
15 Proponents of private equity investments in health care claim that private equity provides access to
16 capital infusions, which may facilitate practice innovation and aid in the adoption of new
17 technological infrastructure [6,8]. Proponents also advocate that private equity can bring “valuable
18 managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase
19 healthcare access by synergistically aligning profit incentives with high quality care provision”
20 [10].

21
22 Critics argue that private equity’s focus on generating large, short-term profits likely establishes an
23 emphasis on profitability over patient care, which creates dual loyalties for physicians working as
24 employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits
25 likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-
26 emphasis on profitable services, limits access to care for certain patient populations (such as
27 uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or
28 Medicare patients), and fundamentally limits physician control over the practice and clinical
29 decision making [5,8,10].

30
31 Despite strong opinions regarding private equity’s incursion into medicine, empirical research on
32 the effects of private equity investments in health care, and the impacts on patient outcomes, is
33 currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because
34 “[p]rivate equity firms aren’t required to publicly disclose acquisitions or sales, and the widespread
35 use of nondisclosure agreements further contributes to opacity about practice ownership and the
36 nature of transactions” [6]. Private equity firms are emerging to be major employers of physicians.
37 Currently, it is estimated that 8% of all private hospitals in the U.S. and 22% of all proprietary for-
38 profit hospitals are owned by private equity firms [11].

39 40 ETHICAL ISSUE

41
42 Private equity firms’ commitment to ensuring high returns on their investments creates a potential
43 ethical dilemma when investing in health care. Whether or not it may be ethically permissible for
44 physicians to sell their practices to private equity firms or for physicians to work as employees for
45 such acquisitions largely depends on how private equity investments impact patient care and
46 outcomes. This report will examine how private equity investments in health care may be ethical,
47 the circumstance and factors to be weighed, as well as how physicians may ethically navigate
48 private equity buyouts and employment.

1 RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

2
3 A major concern of physicians regarding private equity investments in health care is the potential
4 loss of autonomy, which physicians worry could translate into hospital policies designed for
5 profitability and that limit physicians' decision-making and their ability to care for patients [9].
6 Loss of autonomy is also associated with increased physician burnout [12]. There are also valid
7 concerns that private equity ownership leads to increased patient volumes and more expensive and
8 potentially unnecessary procedures [9].
9

10 REVIEW OF RELEVANT LITERATURE

11
12 *Empirical Evidence in Medical Literature*

13
14 More research is needed on the effects of private equity investments in the health care sector, as
15 little empirical evidence exists on how private equity impacts utilization, spending, or patient
16 outcomes. There is widespread concern among physicians that private equity-controlled practices
17 result in worse patient outcomes.
18

19 The best evidence that private equity acquisition of hospitals harms patients is a recent difference-
20 in differences study by Kannan et al of hospital-acquired adverse events and hospitalization
21 outcomes associated with private equity acquisitions of U.S. hospitals [13]. Data from 100%
22 Medicare Part A claims at 51 private equity-acquired hospitals were compared with data from 259
23 matched control hospitals (not acquired by private equity) for hospital stays between 2009 and
24 2019. While there was no differential change in mortality 30 days after hospital discharge, the
25 researchers did find that after private equity acquisition, Medicare beneficiaries admitted to private
26 equity-owned hospitals experienced a 25.4% increase in hospital-acquired conditions compared
27 with those treated at control hospitals. This increase in hospital-acquired conditions, which are
28 established measures of inpatient quality and are considered preventable, was largely driven by a
29 27.3% increase in falls and a 37.7% increase in central line-associated bloodstream infections at
30 private equity-acquired hospitals [13]. The increase in central-line associated infections after
31 private equity acquisition occurred even as these hospitals saw a 16% reduction in percutaneous
32 central line placement. Kannan et al hypothesize that such increases in hospital-acquired infections
33 could result from decreases in staffing, as such adverse events have been shown to be correlated
34 with staffing ratios among nurses and that private equity often will reduce staffing and change the
35 clinician labor mix at acquired hospitals as a cost-cutting strategy [13].
36

37 In another difference-in-differences study of 578 private equity-acquired practices in dermatology,
38 gastroenterology, and ophthalmology matched with a control group of 2,874 non-private equity-
39 acquired practices, Singh et al found a mean increase of 20.2% in charges per claim and a
40 consistent increase in patient utilization over the first eight quarters after acquisition, with the
41 increase in patient utilization primarily driven by a 37.9% increase in visits by new patients [14].
42 Overall, the researchers found that "private equity acquisition was associated with increases in
43 health care spending and several measures of utilization, and some evidence of greater intensity of
44 care" [14]. They also found increased coding intensity, and posit that this finding could be due to
45 either changes in coding and billing practices that have more efficient charge capture or,
46 conversely, could reflect upcoding to increase revenues [14]. The motivating factors behind this
47 impact on coding deserves further study.
48

49 In a systematic review of 55 studies evaluating trends in private equity ownership in health care
50 and the impacts on outcomes, costs, and quality, Borsa et al found that private equity ownership
51 was associated with an increase in cost to patients or payers, primarily from increased charges and

1 rates for services as well as inconclusive, mixed results on how private equity impacts quality of
2 care [10]. The majority of the studies (n=47) evaluated private equity ownership of health care
3 operations in the US, but represented a range of settings, the most common of which were nursing
4 homes (n=17), hospitals (n=9), dermatology (n=9), and ophthalmology (n=7). Only eight studies
5 included health outcomes, with two finding beneficial impacts, three findings harmful impacts, and
6 three finding neutral impacts; the three that found harmful impacts were all studies of nursing
7 homes [10]. These results suggest that private equity may impact segments of the health care
8 industry differently.

9
10 In their analysis of 281 private equity acquisitions involving 610 unique target hospitals, Gao et al
11 found that over an eight-year window, acquisitions were associated with increased profitability, no
12 change in the rate of closures, no statistically significant changes in mortality or readmission rates,
13 and that the percentage of Medicare and Medicaid patients stayed relatively the same [15]. Over
14 the eight year window, private equity-acquired hospitals increased their operating income by 7.4%.
15 Compared to their matched control groups, private equity-acquired hospitals were equally or more
16 likely to survive, contrary to the prevailing narrative. Private equity-acquired hospitals initially
17 experienced a 14% decrease in the number of core workers (medical workers that include
18 physicians, nurses, and pharmacists) over the first four years but over the next four years this
19 difference dissipates to only 2% and is not statistically significant. In contrast, the decline in
20 administrative workers is significant and persistent, with a reduction of 18% within the first four
21 years of acquisition and a 22% reduction by the end of eight years. This reduction in administrative
22 workers was most profound at nonprofit hospitals. Core workers' wages were not found to change,
23 while administrative workers' wages declined by 7%. No changes to patient mortality rates or
24 readmission were found, except for a 0.9% increase in readmission following pneumonia. In
25 looking at rates of stroke, complications and infections during hospitalization as measure of patient
26 outcomes, no statistically significant differences were found between private equity-acquired
27 hospitals, the control group, or non-private equity acquired hospitals. Private equity-acquired
28 hospitals appear to treat a higher number of resource-intensive patients and decrease their
29 outpatient ratio. Gao et al conclude: “[o]verall, our evidence suggests that PE acquirers improve the
30 operating efficiency of target hospitals without a compromise in healthcare quality” [15].

31 *Normative and Substantive Views in Ethics and Medical Literature*

32
33
34 The debate over private equity's incursion into health care often regards private equity acquisitions
35 through a lens of exceptionalism—either negatively or positively. However, although private
36 equity owned hospitals are different in their ownership structure and oversight compared to other
37 traditional health care investors, private equity-acquired hospitals may not be substantively
38 different from other for profit and non-profit hospitals in terms of their stated goals of both
39 solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and
40 that there are likely good and bad actors as is the case in many sectors [6]. They add: “physicians
41 should be aware that private equity's growth is emblematic of broader disruptions in the physician-
42 practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise” [6].

43
44 The corporatization of medicine is not without ethical and professional risks, of course. In their
45 ethical analysis of orthopaedic surgery practices owned by non-physicians, Moses et al note that
46 the incentives and goals of surgeons might be misaligned with those of the investors, pitting patient
47 care against profits; profit maximization might also lead to wasteful overtreatment as well as a loss
48 of physician autonomy within the practice as well as patient autonomy if physicians are encouraged
49 to be more paternalistic to achieve financial goals [3].

1 Veatch notes that business ethics and medical ethics are not inherently at odds but admits that
2 differences do exist [16]. Veatch highlights that physicians are uncomfortable with any removal of
3 professional control that may accompany the increasing commercialization of the physician's role.
4 Veatch points out that paradoxically, despite being open to the profit motive in the practice of
5 medicine, the practice as a whole has shown strong resistance to the commercialization of medical
6 practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental
7 right or a commodity like any other, adding that the notion of health care as a right jeopardizes any
8 profit motive in health care including traditional private practitioner fee-for-service models [16].
9

10 Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human
11 good that society has an obligation to provide in some measure to all citizens [17]. Pellegrino
12 argues that health care is substantively different from traditional market goods—it is not fungible,
13 cannot be proprietary because medical knowledge is possible only due to collective achievements,
14 is realized in part through the patient's own body, and requires an intensely personal relationship—
15 and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine
16 turns any interaction between the patient and physician into a commercial transaction subject to the
17 laws and ethics of business rather than to medical and professional ethics. "In this view,"
18 Pellegrino writes, "inequities are unfortunate but not unjust [...]. In this view of health care,
19 physicians and patients become commodities too" [17]. Rather than claiming that health care is a
20 fundamental right, Pellegrino takes a position of distributive justice to argue that health care is a
21 collective good. Because a good society is one in which each citizen is enabled to flourish, and
22 good health is a condition of human flourishing, society has a moral responsibility to provide
23 health care to all citizens. In this light, health care is both an individual and a social good.
24 Pellegrino also refers to this view as one of "beneficent justice" and explains, "[t]reating health
25 care as a common good implies a notion of solidarity of humanity, i.e., the linkage of humans to
26 each other as social beings" [17]. Pellegrino concludes:
27

28 Understanding health care to be a commodity takes one down one arm of a bifurcating
29 pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking
30 health care as a human good takes us down a divergent pathway to the resolution of
31 injustice through a moral ordering of societal and individual priorities [17].
32

33 Whether health care is understood as a commodity or a human good is of course not always so
34 clear in policy and in practice. What is evident, however, is that as health care has become
35 increasingly commodified, the ethical risks to patients and physicians are being realized as
36 physicians find themselves increasingly working as employees and worrying about the impact that
37 commercial enterprises—such as private equity investments—may be having on patients.
38

39 Private equity represents the latest and most extreme form of health care commercialization that
40 has escalated over the past few decades. This is the very reason why private equity firms became
41 interested in health care in the first place—they recognized that health care as a market was already
42 ripe for investment and future profitability. Private equity firms use the same investment models in
43 health care that they do in other industries—invest in fragmented markets, acquire the most
44 promising targets as a platform, expand through add-on acquisitions, and exit the market once a
45 significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each
46 individual acquisition is typically too small to require review by anti-trust regulators at the Federal
47 Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers
48 and acquisitions in the health care sector [9].

1 Fuse Brown and Hall explain, “[private equity] functions as a divining rod for finding market
2 failures—where PE has penetrated, there is likely a profit motive ripe for exploitation” [1]. They
3 continue that private equity investments pose three primary risks:

4
5 First, PE investment spurs health care consolidation, which increases prices and potentially
6 reduces quality and access. Second, the pressure from PE investors to increase revenue can
7 lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding,
8 harming patients through unnecessary care, excessive bills, and increasing overall health
9 spending. Third, physicians acquired by PE companies may be subject to onerous
10 employment terms and lose autonomy over clinical decisions [1].

11
12 While the profit motive of private equity firms may drive them to take part in less than scrupulous
13 practices, such as private equity’s exploitation of out-of-network surprise billing, there is also
14 potential for private equity to play a more positive role in transforming health care practices [1,18].
15 Powers et al write:

16
17 Ultimately, private equity—a financing mechanism—is not inherently good or bad.
18 Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-
19 service construct, this is intrinsically problematic. But value-based payment models can
20 serve as an important guardrail, helping to ensure that financial return to private equity
21 investors are appropriately aligned with system goals of access, quality, equity, and
22 affordability [18].

23
24 Private equity firms could help accelerate changes in health care payment and delivery towards
25 value-based models. With such models, where financial performance is tied to quality and value,
26 private equity may be incentivized to invest in changes that support better health and lower costs
27 [18].

28
29 While more research is needed on the impacts of private equity investments in health care, private
30 equity firms’ involvement in health care does not appear to be exceptional within the current
31 corporate transformation of the profession and thus is inherently no more or less ethical than this
32 current trend that has penetrated health care and the practice of medicine far beyond interactions
33 with private equity. As Fuse Brown and Hall point out, “PE investment in health care is just the
34 latest manifestation of the long trend of increasing commercialization of medicine. And so long as
35 the U.S. treats health care as a market commodity, profit-seeking will persist” [1].

36
37 Ikrum et al provide a balanced view of the situation and offer some recommendations for
38 partnering with private equity in health care:

39
40 While PE involvement in health care delivery invokes inherent concerns, it has provided
41 much-needed capital for many primary care practices to mitigate the effects of the
42 pandemic and to potentially undertake care delivery innovations such as population health
43 management under value-based payment models. To make partnerships with private
44 investors work, providers need to select the right investors, establish strategies upfront to
45 address misaligned objectives, and define a successful partnership by setting goals for and
46 transparently reporting on indicators that reflect both financial and clinical performance.
47 Safeguards and regulations on sales may also protect patients and providers [7].

1 RELEVANT LAWS

2
3 Fuse Brown and Hall write that despite the market consolidation that results from private
4 equity acquisitions within health care, these acquisitions generally go unreported and
5 unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-
6 Rodino (HSR) Act and that there are currently no legal guidelines for assessing the collective
7 market effects of add-on acquisitions. However, they do note:

8
9 Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade
10 Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers
11 and acquisitions where the effect of the transaction may be “substantially to lessen
12 competition, or to tend to create a monopoly.” To determine whether a transaction may
13 threaten competition, antitrust agencies analyze whether the transaction will enhance
14 the market power of the transacting parties in a given geographic and product market.
15 [...] Typically, the FTC oversees health care acquisitions (other than insurance) [1].
16

17 To protect patients from harmful billing practices, the federal government has passed the No
18 Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most
19 states have similar laws, such as those barring fee-splitting and self-referral, and several states
20 have passed laws regulating or restricting the use of gag clauses in physician contracts. The
21 FTC has also recently proposed a rule banning noncompete clauses in all employment
22 contracts [1].
23

24 The federal Emergency Medical Treatment and Labor Act (EMTALA) ensures that hospitals
25 with an emergency department provide all patients access to emergency services regardless of
26 their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58%
27 of community hospitals, provide some level of charity care as a condition for their tax-exempt
28 status, which the Internal Revenue Service (IRS) defines as “free or discounted health services
29 provided to persons who meet the organization’s eligibility criteria for financial assistance and
30 are unable to pay for all or a portion of the services” [19].
31

32 RELEVANT AMA POLICY PROVISIONS

33
34 Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and
35 venture capital investment in health care, and its recommendations were adopted as Policy [H-
36 160.891](#), “Corporate Investors.” This policy delineates 11 factors that physicians should consider
37 before entering into partnership with corporate investors, including alignment of mission, vision,
38 and goals; the degree to which corporate partners may require physicians to cede control over
39 practice decision making; process for staff representation on the board of directors and medical
40 leadership selection; and retaining medical authority in patient care and supervision of
41 nonphysician practitioners.
42

43 Our AMA further developed and published materials to assist physicians contemplating partnering
44 with private equity and venture capital firms:
45

- 46 • [Venture Capital and Private Equity: How to Evaluate Contractual Agreements](#)
- 47 • [Model Checklist: Venture Capital and Private Equity Investments](#)
- 48 • [Snapshot: Venture Capital and Private Equity Investments](#)

1 Policy [H-310.901](#), “The Impact of Private Equity on Medical Training,” encourages GME training
2 institutions and programs to “demonstrate transparency on mergers and closures, especially as it
3 relates to private equity acquisition” and asserts that our AMA will “[s]upport publicly funded
4 independent research on the impact that private equity has on graduate medical education.”

5
6 RELEVANT *CODE* PROVISIONS

7
8 The AMA *Code of Medical Ethics* [Opinion 11.2.1](#), “Professionalism in Health Care Systems,”
9 acknowledges that “[p]ayment models and financial incentives can create conflicts of interest
10 among patients, health care organizations, and physicians” and offers recommendations for
11 physicians within leadership positions regarding the ethical use of payment models that influence
12 where and by whom care is delivered. Key elements include the need for transparency, fairness, a
13 primary commitment to patient care, and avoiding overreliance on financial incentives that may
14 undermine physician professionalism.

15
16 [Opinion 11.2.2](#), “Conflicts of Interest in Patient Care,” clearly states: “[t]he primary objective of
17 the medical profession is to render service to humanity; reward or financial gain is a subordinate
18 consideration. [...] When the economic interests of the hospital, health care organization, or other
19 entity are in conflict with patient welfare, patient welfare takes priority.”

20
21 [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” stipulates that physicians’
22 fundamental ethical obligation to patient welfare requires physicians to carefully consider any
23 contract to deliver health care services they may enter into to ensure they do not create untenable
24 conflicts of interest. The opinion states that physicians should negotiate or remove “any terms that
25 unduly compromise physicians’ ability to uphold ethical standards.” However, it should be
26 acknowledged that physicians have little leverage in changing entire payment structures or
27 reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians
28 in private practice often feel that they have little leverage in negotiating the sale of their practice;
29 they simply receive an offer and are told they can take it or leave it.

30
31 [Opinion 11.2.3.1](#), “Restrictive Covenants,” states: “[c]ovenants-not-to-compete restrict
32 competition, can disrupt patient care, and may limit access to care” and that physicians should not
33 enter into covenants that “[u]nreasonably restrict the right of a physician to practice medicine for a
34 specified period of time or in a specified geographic area on termination of a contractual
35 relationship”. However, many hospitals and hospital systems today now routinely include
36 noncompete clauses as part of their physician contracts. These clauses put physicians at risk of
37 violation of professional obligations and their widespread use has the potential to undermine the
38 integrity of the profession as a whole.

39
40 ETHICAL ANALYSIS

41
42 The ethical concerns raised by private equity investments in health care are not unique but instead
43 represent ethical dilemmas that exist due to the very nature of treating health care as a commodity.
44 While private equity firms may choose to pursue financial incentives that are counter to the
45 physicians’ ethical and professional responsibilities, private equity’s investment in health care is
46 not inherently unethical. However, caution is warranted so it is crucial that policy guidelines be
47 developed to ensure that private equity-acquired hospitals, hospital systems, and physician
48 practices continue to function in an ethical manner that prioritizes patients and patient care over
49 profits. Policies that require greater transparency and disclosure of data on private equity
50 ownership, greater state regulatory control over private equity acquisitions, closing payment and
51 billing loopholes, rules requiring an independent clinical director on the Board of private equity

1 firms engaged in health care, and means for physicians to help set goals and measure outcomes to
2 ensure the alignment of corporate and clinical values should be considered [7].

3
4 Though the current literature is conflicting, there are valid concerns that private equity investment
5 in health care might negatively impact patient outcomes. Since serious potential risks and conflicts
6 of interest do exist, it is essential for physicians considering entering into partnership with private
7 equity firms to evaluate their contracts and require that the agreements are consistent with the
8 norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an
9 employee of a private equity-owned hospital should ensure that their contract does not place them
10 in an untenable conflict of interest or compromise their ability to fulfill their ethical and
11 professional obligations to patients [8].

12
13 It is the conclusion of the Council on Ethical and Judicial Affairs (CEJA) that new ethics guidance
14 specifically addressing private equity investment in health care is not needed. There already exists
15 rich House policy and AMA published materials addressing private equity investments in health
16 care. Furthermore, the ethical issues that private equity involvement raise are not limited to that
17 specific sphere of health care investment. In light of the fact that private equity is not unique in the
18 ethical concerns it raises, the Council finds that existing guidance in [Opinion 11.2.2](#), “Conflicts of
19 Interest in Patient Care,” and [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” are
20 sufficient at the present time to address the concerns raised by the increasing investment by private
21 equity in health care; however, it may be appropriate to amend current guidance to more clearly
22 encompass partnerships with private equity firms and the ethical concerns that they raise for both
23 physicians seeking capital to support their private practice as well as physicians entering into
24 employment contracts with private equity-owned hospitals.

25 26 RECOMMENDATIONS

27
28 In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that
29 [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” be amended by addition and deletion
30 as follows and the remainder of this report be filed:

31
32 Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other
33 considerations, including personal financial interests. This obligation requires ~~them to that~~
34 before entering into contracts to deliver health care services, physicians consider carefully the
35 proposed contract to assure themselves that its terms and conditions of contracts to deliver
36 health care services before entering into such contracts to ensure that those contracts do not
37 create untenable conflicts of interest or compromise their ability to fulfill their ethical and
38 professional obligations to patients.

39
40 Ongoing evolution in the health care system continues to bring changes to medicine, including
41 changes in reimbursement mechanisms, models for health care delivery, restrictions on referral
42 and use of services, clinical practice guidelines, and limitations on benefits packages. While
43 these changes are intended to enhance quality, efficiency, and safety in health care, they can
44 also put at risk physicians’ ability to uphold professional ethical standards ~~of informed consent~~
45 ~~and fidelity to patients~~ and can impede physicians’ freedom to exercise independent
46 professional judgment and tailor care to meet the needs of individual patients.

47
48 As physicians seek capital to support their practices or enter into various differently structured
49 contracts to deliver health care services—with group practices, hospitals, health plans,
50 investment firms, or other entities—they should be mindful that while ~~many some~~
51 arrangements have the potential to promote desired improvements in care, some other

1 arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere
2 with physician autonomy.

3
4 When ~~contracting~~ partnering with entities, or having a representative do so on their behalf, to
5 provide health care services, physicians should:

6
7 (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and
8 ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the
9 arrangement:

10
11 (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms,
12 financial or performance incentives, restrictions on care, or other mechanisms intended
13 to influence physicians' treatment recommendations or direct what care patients
14 receive, in keeping with ethics guidance;

15
16 (ii) does not compromise the physician's own financial well-being or ability to provide
17 high-quality care through unrealistic expectations regarding utilization of services or
18 terms that expose the physician to excessive financial risk;

19
20 (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

21
22 (iv) includes a mechanism to address grievances and supports advocacy on behalf of
23 individual patients;

24
25 (v) is transparent and permits disclosure to patients.

26
27 (vi) enables physicians to have significant influence on, or preferably outright control of,
28 decisions that impact practice staffing.

29
30 (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability
31 to uphold ethical or professional standards.

32
33 When entering into contracts as employees, preferably with the advice of legal and ethics
34 counsel, physicians must:

35
36 (c) Advocate for contract provisions to specifically address and uphold physician ethics and
37 professionalism.

38
39 (d) Advocate that contract provisions affecting practice align with the professional and ethical
40 obligations of physicians and negotiate to ensure that alignment.

41
42 (e) Advocate that contracts do not require the physician to practice beyond their professional
43 capacity and provide contractual avenues for addressing concerns related to good practice,
44 including burnout or related issues.

45
46
47 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. *Stanford Law Review* 2024;76.
2. Crowley R, Atiq O, Hilden D, Health and Public Policy Committee of the American College of Physicians. Financial profit in medicine: A position paper from the American College of Physicians. *Annals of Internal Medicine* 2021;174(10):1447-9.
3. Moses MJ, Weiser LG, Bosco III JA. The corporate practice of medicine: Ethical implications of orthopaedic surgery practice ownership by non-physicians. *JBS* 2020;102(11):e53.
4. AMA analysis shows most physicians work outside of private practice. In: American Medical Association. <https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice#:~:text=Employment%20status,2018%20and%2053.2%25%20in%202012>.
5. Gondi S, Song Z. Potential implications of private equity investments in health care delivery. *JAMA* 2019;321(11):1047-8.
6. Zhu JM, Polsky D. Private equity and physician medical practices-navigating a changing ecosystem. *NEJM* 2021;384(11):981-3.
7. Ikram U, Aung KK, Song Z. Private equity and primary care: Lessons from the field. *NEJM Catalyst Innovations in Care Delivery* 2021;2(6).
8. DeCamp M, Snyder Sulmasy L, American College of Physicians Ethics, Professionalism and Human Rights Committee. Ethical and professionalism implications of physician employment and health care business practices: a policy paper from the American College of Physicians. *Ann of Intern Med* 2021;174(6):844-51.
9. Appelbaum E, Batt R. Private equity buyouts in healthcare: who wins, who loses? Institute for New Economic Thinking Working Paper Series 2020(118). doi.org/10.36687/inetwp118
10. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ* 2023;382.
11. PESP Private Equity Hospital tracker. In: Private Equity Stakeholder Project PESP. <https://pestakeholder.org/private-equity-hospital-tracker/>.
12. Dillon EC, Tai-Seale M, Meehan A, Martin V, Nordgren R, Lee T, Nauenberg T, Frosch DL. Frontline perspectives on physician burnout and strategies to improve well-being: interviews with physicians and health system leaders. *Journal of General Internal Medicine* 2020;35:261-7.
13. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147
14. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. *JAMA Health Forum* 2022;3(9):e222886-e222886.
15. Gao J, Sevilir M, Kim YS. Private equity in the hospital industry. *European Corporate Governance Institute–Finance Working Paper* 2021;787.
16. Veatch RM. Ethical dilemmas of for-profit enterprise in health care. In *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment*. Gray BH, ed. National Academy Press, Washington DC, 1983.
17. Pellegrino ED. The commodification of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic. *J Med Philos* 1999;24(3):243-266. doi:10.1076/jmep.24.3.243.2523
18. Powers BW, Shrank WH, Navathe AS. Private equity and health care delivery: value-based payment as a guardrail?. *JAMA* 2021;326(10):907-8.

19. Levinson Z, Hulver S, Neuman T. Hospital charity care: how it works and why it matters. KFF 2022 Nov 3. <https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/>

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-24

Subject: Physicians’ Use of Social Media for Product Promotion and Compensation
(Resolution 25, A-22)

Presented by: David A. Fleming, MD, Chair
Referred to: Reference Committee on Amendments to Constitution and Bylaws
(, MD, Chair)

1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution
2 025), “Use of Social Media for Product Promotion and Compensation” which asked that the
3 American Medical Association (AMA) “study the ethical issues of medical students, residents,
4 fellows, and physicians endorsing non-health related products through social and mainstream
5 media for personal or financial gain.”
6

7 This report by the Council on Ethical and Judicial Affairs (CEJA) explores ethical issues posed by
8 this use of social media and reviews existing guidance in the AMA *Code of Medical Ethics (Code)*.
9

10 BACKGROUND

11
12 Resolution 025 details the recent phenomenon of physicians’ involvement in promotions and
13 endorsements on social media. While Resolution 025 is limited to the context of physicians
14 promoting non-health related products through social media, this report encompasses the issue
15 broadly in the contexts of promoting both non-health related and/or health related products. The
16 concept of social media has changed dramatically in the last couple of decades and has altered how
17 consumer goods and services are advertised, promoted, and sold. Social media now accounts for a
18 broad range of communication—e.g., Tik Tok, Instagram, Facebook, X (formerly Twitter),
19 YouTube—that can reach millions of people, and now often involves “influencing”, where
20 individuals promote or sell goods and services or promote themselves (e.g. their personality or
21 lifestyle) as a financial venture.
22

23 ETHICAL CONCERNS

24
25 Physicians’ and medical students’ sale and promotion of products or services and use of social
26 media raises several ethical concerns. (1) These practices may damage the patient-physician
27 relationship. If patients feel pressured to purchase products or services, this may undermine the
28 trust that grounds patient-physician relationships, since it raises questions about whether physicians
29 are fulfilling their fiduciary duty to put patients’ interests above their own financial interests. (2) If
30 inappropriate pressure is applied, then selling and promotion of products may result in the
31 exploitation of patient vulnerability. (3) If physicians lend their credibility as medical professionals
32 to products or services that are not supported by peer-reviewed evidence or are of questionable

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

1 value, then they may put patient well-being and the integrity of the profession in jeopardy in the
2 interest of profit-making.

3 4 Welfare of the Patient and the Patient-Physician Relationship

5
6 The sale and promotion of goods and services by physicians has the potential to negatively affect
7 the welfare of patients. If a physician puts their financial interests above the interests of the
8 patients, then this undercuts the foundational ethical principle that physicians must regard their
9 “responsibility to the patient as paramount. [Principle VIII]. In addition, since patients are
10 “vulnerable and dependent on the doctor’s expertise” and there is an “asymmetry of knowledge”
11 between patients and physicians, there is a risk that patients may be exploited and this, in turn, can
12 “undermine a patient’s trust” [1]. Further, if patients find out about a physician’s financial
13 incentive to recommend certain products or services after the fact, they may feel that they have
14 been purposefully deceived, and so have reason to distrust both that individual physician and the
15 profession as a whole. It is therefore imperative that physicians conscientiously distinguish when
16 they are acting in their professional capacity by recommending products or services intended for
17 patient benefit or public health, and when they are acting as commercial agents independent of
18 their professional identity.

19 20 Integrity of the Profession

21
22 Physician sales and promotion of products and services may also damage the integrity of the
23 profession. Physicians have an ethical duty to uphold professional standards in their role as
24 physician in all areas of life. A key principle of professional integrity is that physicians should
25 recognize that they carry the authority of their professional role with them into other social spheres.
26 Physicians “engage in a number of roles” which include conveyors of information, advocates,
27 experts, and commentators on medically related issues [2]. For many physicians, “navigating
28 successfully among the potentially overlapping roles ...poses challenges.” [2] Physicians “carry
29 with them heightened expectations as trusted...representatives of the medical profession.” [2]
30 Physicians should be aware that these expectations cannot be entirely separated from their personal
31 identity either online or elsewhere and should take care to curate their social media presence
32 accordingly.

33 34 PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

35
36 The concept of social media has changed since the technology’s first appearance and widespread
37 adoption. Today, social media platforms are broadly internet-enabled technologies that enable
38 individuals to have a presence online and ability to share opinions and self-generated media content
39 to a wide audience.

40
41 Opinion 2.3.2 “Professionalism in Social Media” reflects an outdated understanding of the types
42 and uses of social media, modeling its guidance on traditional sites such as Facebook, where the
43 primary purposes are social networking among friends and colleagues, and perhaps also
44 disseminating beneficial public health messages. While guidance that addresses these uses is still
45 necessary (and so should be retained), modifications are required to reflect the fact that social
46 media can now be used as a form of marketing intended to financially benefit individuals and
47 corporations. The ethical concerns that arise in this context mirror those that arise in other
48 situations where physicians are selling and promoting goods and services, that is, use of social
49 media by medical professionals can undermine trust and damage the integrity of patient-physician
50 relationships and the profession as a whole when physicians inappropriately use their social media
51 presence to promote personal interests.

1 CONCLUSION

2
3 Updating 2.3.2 “Professionalism in the Use of Social Media” so that it includes guidance on using
4 social media to sell and promote products makes it clear that the consolidated guidance clearly
5 applies to the concerns raised in Resolution 025. Revising this also provides an opportunity to
6 update language to reflect the current realities of technology and contemporary business practices.
7

8 RECOMMENDATION

9
10 In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:
11 Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as
12 follows and the remainder of this report be filed:
13

14 Social media—internet-enabled communication platforms—enable individual medical students
15 and physicians to have both a personal and a professional presence online. Social media can
16 foster collegiality and camaraderie within the profession as well as provide opportunities to
17 widely disseminate public health messages and other health communications. However, use of
18 social media by medical professionals can also undermine trust and damage the integrity of
19 patient-physician relationships and the profession as a whole, especially when medical students
20 and physicians use their social media presence to promote personal interests.
21

22 Physicians and medical students should be aware that they cannot realistically separate their
23 personal and professional personas entirely online and should curate their social media
24 presence accordingly. Physicians and medical students therefore should:
25

- 26 (a) When publishing any content, consider that even personal social media posts have the
27 potential to damage their professional reputation or even impugn the integrity of the
28 profession.
29
- 30 (b) Respect professional standards of patient privacy and confidentiality and refrain from
31 publishing patient information online without appropriate consent.
32
- 33 (c) Maintain appropriate boundaries of the patient-physician relationship in accordance with
34 ethics guidance if they interact with their patients through social media, just as they would
35 in any other context.
36
- 37 (d) Use privacy settings to safeguard personal information and content, but be aware that once
38 on the Internet, content is likely there permanently. They should routinely monitor their
39 social media presence to ensure that their personal and professional information and
40 content published about them by others is accurate and appropriate.
41
- 42 (e) Publicly disclose any financial interests related to their social media content, including, but
43 not limited to, paid partnerships and corporate sponsorships.
44
- 45 (f) When using social media platforms to disseminate medical health care information, ensure
46 that such information is useful and accurate based on professional medical judgment.
47

48 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Council on Ethical and Judicial Affairs, CEJA Report 5-I-97, "Sale of Non-Health Related Goods." <https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.5%20Sale%20of%20non-health-related%20goods%20--%20background%20reports.pdf>.
2. Council on Ethical and Judicial Affairs, CEJA Report 2-I-17, "Ethical Physician Conduct in the Media." <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/ceja-report-2-i17.pdf>.
3. Council on Ethical and Judicial Affairs, CEJA Report 1-A-99, "Sale of Health-Related Products form Physician's Offices." <https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.4%20Sale%20of%20health-related%20products%20--%20background%20reports.pdf>.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-A-24

Subject: CEJA’s Sunset Review of 2014 House Policies

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. This policy reads as follows, laying out the parameters for review
4 and specifying the needed procedures:

- 5
6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates
8 to retain it. Any action of our AMA House that reaffirms or amends an existing policy
9 position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for
10 another 10 years.
- 11
12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies
15 shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that
16 has been asked to review policies shall develop and submit a report to the House of
17 Delegates identifying policies that are scheduled to sunset; (d) For each policy under
18 review, the reviewing council can recommend one of the following actions: (i) retain the
19 policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with
20 more recent and like policy; (e) For each recommendation that it makes to retain a policy in
21 any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The
22 Speakers shall determine the best way for the House of Delegates to handle the sunset
23 reports.
- 24
25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy
26 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
27 current policy, or has been accomplished.
- 28
29 4. The AMA councils and the House of Delegates should conform to the following guidelines
30 for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or
31 directive has been accomplished; or (c) when the policy or directive is part of an
32 established AMA practice that is transparent to the House and codified elsewhere such as

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

1 the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies
2 and Practices.

3

4 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

5

6 6. Sunset policies will be retained in the AMA historical archives.

7

8 RECOMMENDATION

9

10 The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that
11 are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of
12 this report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500.

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
H-140.898	Medical Profession Opposition to Physician Participation in Execution	Our AMA strongly reaffirms its opposition to physician participation in execution.	Retain; remains relevant.
H-140.950	Physician Participation in Capital Punishment	<p>Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following:</p> <p>(1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.</p> <p>(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.</p> <p>(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.</p> <p>Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.</p> <p>(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians</p>	Retain; remains relevant.

		who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician.	
H-140.963	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
H-140.999	Our AMA and Bioethics	Our AMA requests official representation on any federal advisory committee or commission dealing with ethical issues of interest to medicine.	Retain; remains relevant.
H-140.963	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
H-265.992	Expert Witness Testimony	Our AMA: (1) encourages each state medical society to work with its state licensing board toward the development of effective disciplinary measures for physicians who provide fraudulent testimony; (2) provides legal and advocacy support to those medical and specialty organizations who seek to devise programs designed to discipline physicians for unprofessional conduct relative to expert witness testimony; (3) continues to study and work with interested organizations to address the inherent difficulties in conducting the peer review of physicians who provide expert witness testimony; (4) continues to educate physicians about ethical guidelines and professional responsibility regarding the provision of expert witness testimony; (5) encourages each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process. (6) encourages each state medical society to assist its state licensing board in the peer review process of expert witnesses by providing an expert witness committee program similar to the one in the state of Florida; (7) works with the Federation of State Medical Boards to address problems regarding out-of-state expert witnesses; and	Retain; remains relevant.

		(8) acts as a clearinghouse for advice and support as the state medical associations develop their own expert witness committee programs.	
H-270.961	Medical Care Must Stay Confidential	Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.	Retain; remains relevant.
H-405.958	Physician Right to Conscience	Our AMA supports high standards of civility and respect among physicians amidst differing political beliefs, aspects of conscience and ethical views because debate and expression of disagreement is healthy and essential to the improvement of medicine, and physicians should communicate any differences in a civil and professional manner.	Retain; remains relevant.
H-65.997	Human Rights	Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-24)

Introduced by: Integrated Physician Practice Section

Subject: Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the significance and incidence of physician and healthcare workforce burnout and
2 workplace stress has increased dramatically; and
3

4 Whereas, burnout among healthcare professional has shown to negatively impact the quality of
5 care, patient safety, and healthcare system operations; and
6

7 Whereas, there are many individual, systemic, and collective factors that contribute to physical
8 and mental health and, therefore, a sense of wellbeing or lack thereof, which may increase the
9 likelihood of burnout; and
10

11 Whereas, there is ongoing research to identify and better understand workplace and individual
12 stresses that contribute to burnout and can diminish an individual's sense of wellbeing; and
13

14 Whereas, individual health history and biological data can provide valuable insights into physical
15 and mental health, and the collection and use of personal and biological data offer potential
16 avenues to support the wellbeing of healthcare professionals, including the early identification of
17 burnout and developing prevention strategies; and
18

19 Whereas, the use of such data must be done in a manner that respects individual privacy rights
20 and ethical considerations; and
21

22 Whereas, the healthcare community currently lacks comprehensive, standardized guidelines for
23 the ethical collection and use of this data in the context of workforce wellbeing; and
24

25 Whereas, the management of such sensitive data raises significant privacy, security, and ethical
26 issues that must be carefully addressed to ensure the rights and interests of individuals are
27 protected; therefore be it
28

29 RESOLVED, that our American Medical Association monitor and report on the research
30 regarding technology, measures, and effective use of personal and biological data which
31 supports professional workforce wellbeing and mitigates burnout (Directive to Take Action); and
32 be it further
33

34 RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of
35 personal and biological data for the professional workforce (Directive to Take Action).
36

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

Received: 4/17/2024

RELEVANT AMA POLICY

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

[AMA Principles of Medical Ethics: I,II,IV](#)

Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmed: A-22

Factors Causing Burnout H-405.948

Our AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.
Citation: Res. 208, I-22

Physician Health Programs H-405.961

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.
Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of: Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 402, A-12; Modified: BOT Rep. 15, A-19

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.
Citation: Res. 723, A-22; Reaffirmed: I-22

Peer Support Groups for Second Victims D-405.980

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the "second victim phenomenon"; and (2) will work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" on our physician workforce.
Citation: Res. 702, A-19

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

Citation: Res. 308, I-98; Reaffirmed: A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

Citation: Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and Appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

Citation: CME Rep. 06, A-19; Modified: Res. 326, A-22

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").

2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.

3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

5. Our AMA encourages the ACGME to:

a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.

b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.

c) Use, where possible, recommendations from respective specialty societies and evidence-based

approaches to any future revision or introduction of clinical and educational work hour rules.

d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:

a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.

c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.

d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).

b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.

c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."

f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.

g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.

i) Scheduled time providing patient care services of limited or no educational value should be minimized.

j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.

k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmed: A-22

Physician and Medical Staff Member Bill of Rights H-225.942

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMD Rep. 5, A-21; Reaffirmed: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-24)

Introduced by: Medical Student Section and Resident & Fellow Section

Subject: Removal of the Interim Meeting Resolution Committee

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, AMA Bylaws 2.12.1.1 and 2.13.13 indicate that the Interim Meeting Resolution
2 Committee limits consideration of resolutions to those that pertain to “advocacy and legislation”
3 or “ethics” or that “requir[e] action prior to the following Annual Meeting”; and
4

5 Whereas, six months after the Board of Trustees recommended formation of the Resolution
6 Committee, the Report of the Executive Vice President at Interim 2002 (I-02) noted that “while I
7 appreciate the need to streamline, I strongly believe that everything the AMA does is advocacy,”
8 and elaborated that “this includes activities you might not initially view as advocacy, like the
9 public stands we take on issues of public health and science”¹; and
10

11 Whereas, over the course of 8 years between I-12 and I-19 (up till the implementation of Special
12 Meetings during COVID), the average number of resolutions historically not considered based
13 on Resolution Committee recommendations was less than 7²; and
14

15 Whereas, from I-12 to I-19, the small number of items historically not considered based on
16 Resolution Committee recommendations ranged from 2 to 10 (2 at I-19, 8 at I-18, 4 at I-17, 3 at
17 I-16, 9 at I-15, 8 at I-14, 10 at I-13, and 9 at I-12)²; and
18

19 Whereas, the low number of resolutions historically screened out by the Interim Meeting
20 Resolution Committee indicates that the House has successfully managed its volume of
21 business without significant benefit from the Resolution Committee; and
22

23 Whereas, despite perceptions of increased resolution volume, we have concluded business
24 early at all 4 HODs since returning from COVID, including a full day earlier at A-23; and
25

26 Whereas, the use of the Interim Meeting Resolution Committee functionally means that
27 resolutions relating to meeting operations, Bylaws, task forces, and other organizational
28 initiatives and resolutions requesting studies should be withheld until the Annual Meeting, as
29 they would be unlikely to meet Resolution Committee criteria, unnecessarily delaying regular
30 functions of our HOD and AMA until those resolutions can be introduced in June; and
31

32 Whereas, the Resolution Committee does not meet at all to deliberate, as each member
33 individually and privately simply checks off whether they approve a resolution; and
34

35 Whereas, no criteria exist for whether resolutions should be considered if they relate to reports
36 or to other resolutions approved for consideration, leading to unclear rationale for decisions; and
37

38 Whereas, even resolutions clearly related to advocacy, ethics, or urgency (including titles
39 mentioning “Policy Reform,” “Regulation,” names of specific legislation, or issues pending

1 imminent Congressional votes or executive agency decisions with time-limited comment
2 periods) are regularly screened out, leading to unclear rationale for decisions; and

3
4 Whereas, while a majority vote can consider a screened-out resolution, smaller and newer
5 delegations are at baseline disadvantaged in overturning a negative decision, which conflicts
6 with democratic principles of fairness and protection of minority rights and views, a central tenet
7 of our House's parliamentary procedure to ensure all voices are heard; and

8
9 Whereas, many delegations' advocacy priorities were negatively affected by the narrow
10 resolution criteria at I-23 and several, not just the MSS and RFS, attempted extractions; and

11
12 Whereas, the removal of the Resolution Committee could better balance the load between the
13 Interim and Annual Meetings, rather than the Annual Meeting seeing an increased load due to
14 resolution resubmissions, which also leads to increased report load at subsequent Annual
15 Meetings for resolutions that were referred a year prior; and

16
17 Whereas, while the Interim Meeting is a day shorter, we still concluded business early the last
18 two years, many screened-out resolutions would likely be handled agreeably by Reference
19 Committees without extraction, and our House already uses other ways to effectively self-
20 regulate volume of debate (e.g., calling the question, shortening testimony time); and

21
22 Whereas, better methods to manage a modest increase in Interim Meeting business, without
23 needing to extend the meeting, could include using the same number of Reference Committees
24 as the Annual Meeting, since the Interim Meeting currently only uses 6 and the Annual
25 Meeting's 8 Reference Committees more evenly distribute additional business across additional
26 sessions on both Saturday afternoon and Sunday morning; therefore be it

27
28 RESOLVED, that our American Medical Association remove the Resolution Committee from
29 Interim Meetings by amending AMA Bylaw B-2.13.3, "Resolution Committee," by deletion as
30 follows:

31
32 **Resolution Committee. B-2.13.3**

33 ~~The Resolution Committee is responsible for reviewing resolutions~~
34 ~~submitted for consideration at an Interim Meeting and determining~~
35 ~~compliance of the resolutions with the purpose of the Interim~~
36 ~~Meeting.~~

37 ~~2.13.3.1 Appointment. The Speaker shall appoint the members of~~
38 ~~the committee. Membership on this committee is restricted to~~
39 ~~delegates.~~

40 ~~2.13.3.2 Size. The committee shall consist of a maximum of 31~~
41 ~~members.~~

42 ~~2.13.3.3 Term. The committee shall serve only during the meeting~~
43 ~~at which it is appointed, unless otherwise directed by the House of~~
44 ~~Delegates.~~

45 ~~2.13.3.4 Quorum. A majority of the members of the committee shall~~
46 ~~constitute a quorum.~~

47 ~~2.13.3.5 Meetings. The committee shall not be required to hold~~
48 ~~meetings. Action may be taken by written or electronic~~
49 ~~communications.~~

50 ~~2.13.3.6 Procedure. A resolution shall be accepted for~~
51 ~~consideration at an Interim Meeting upon majority vote of committee~~
52 ~~members voting. The Speaker shall only vote in the case of a tie. If~~

1 a resolution is not accepted, it may be submitted for consideration
2 at the next Annual Meeting in accordance with the procedure in
3 Bylaw 2.11.3.1.

4 ~~2.13.3.7 Report. The committee shall report to the Speaker. A~~
5 ~~report of the committee shall be presented to the House of~~
6 ~~Delegates at the call of the Speaker. (Modify Bylaws); and be it~~
7 ~~further~~

8
9 RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings,
10 which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1,
11 "Business of Interim Meeting," by deletion as follows:

12
13 **2.12.1.1 Business of Interim Meeting**

14 ~~The business of an Interim Meeting shall be focused on advocacy~~
15 ~~and legislation. Resolutions pertaining to ethics, and opinions and~~
16 ~~reports of the Council on Ethical and Judicial Affairs, may also be~~
17 ~~considered at an Interim Meeting. Other business requiring action~~
18 ~~prior to the following Annual Meeting may also be considered at an~~
19 ~~Interim Meeting. In addition, any other business may be considered~~
20 ~~at an Interim Meeting by majority vote of delegates present and~~
21 ~~voting. (Modify Bylaws)~~

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

Received: 4/19/2024

REFERENCES

1. Report of the Executive Vice President, American Medical Association Interim 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
2. American Medical Association Archives. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.

RELEVANT AMA Policy

B-11.1 Parliamentary Procedure

In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

G-600.054 Procedures of the House of Delegates

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
 - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
 - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.

3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly. [Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17]

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House. [Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-24)

Introduced by: Medical Student Section

Subject: Amendments to AMA Bylaws to Enable Medical Student Leadership
Continuity

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, terms on the Medical Student Section (MSS) Governing Council, as the medical
2 student member on an AMA Council or the AMA Board of Trustees, or as the MSS
3 representative on the Minority Affairs Section or Women Physicians Section Governing Councils
4 are one year in length and commence after the Annual Meeting; and
5

6 Whereas, the AMA Bylaws defining cessation of eligibility for these positions state that if the
7 medical student leader “graduates from an educational program within 90 days prior to an
8 Annual Meeting,” they shall be permitted to continue to serve “until the completion of the Annual
9 Meeting”; and
10

11 Whereas, some students graduate off-cycle during the fall semester rather than the spring
12 semester, including some in November, over 180 days prior to the AMA Annual Meeting; and
13

14 Whereas, graduation off-cycle is more common for students with disabilities or chronic illness,
15 students who have taken leave of absence for personal or familial reasons, students who have
16 overcome medical or personal challenges, students from underrepresented backgrounds,
17 students who have pursued unique opportunities, and students who have faced obstacles
18 during their educational journey; and
19

20 Whereas, students who graduate off-cycle would technically be forced under the AMA Bylaws to
21 vacate their AMA national leadership position, leading to discontinuity of Medical Student
22 Section leadership, disrupting MSS internal operations and priorities, and curtailing these
23 students’ opportunity to grow as leaders; and
24

25 Whereas, the MSS Assembly has repeatedly unanimously expressed their desire that students
26 who graduate off-cycle should be able to complete their leadership terms; therefore be it
27

28 RESOLVED, that our American Medical Association amend AMA Bylaws 3.5.6.3, 6.11, 7.3.2,
29 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section
30 Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section
31 Representatives on other Governing Councils for up to 200 days after graduation. (Modify
32 Bylaws)
33

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

Received: 4/5/2024

RELEVANT AMA POLICY

Medical Student Trustee - Cessation of Enrollment B-3.5.6.3

The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

Term of Resident/Fellow Physician or Medical Student Member B-6.11

A resident/fellow physician or medical student member of a Council who completes residency or fellowship or who graduates from an educational program within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

Medical Student Section - Cessation of Eligibility B-7.3.2

If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

Minority Affairs Section - Section Representatives on the Governing Council B-7.7.3.1

If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which he or she ceases to meet the membership requirement of the respective section.

Women Physicians Section - Section Representatives on the Governing Council B-7.10.3.1

If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which she or he ceases to meet the membership requirement of the respective section.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-24)

Introduced by: Thomas W. Eppes, MD, Mark D. Townsend, MD MHCM, and Billie L. Jackson, MD.

Subject: The Rights of Newborns that Survive Abortion

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, our American Medical Association recognizes healthcare as a human right; and
2
3 Whereas, the AMA has policy 2.2.4(d) Treatment Decisions for the Seriously Ill Newborn, which
4 states, "Initiate life sustaining and life enhancing treatment when the child's prognosis is largely
5 uncertain"; and
6
7 Whereas, AMA Code 2.2.1(I) calls on the physician to seek consultation when there is a
8 reversible life-threatening condition and the patient (If capable) or parents or guardian refuses
9 treatment the physician believes is clearly the patient's best interest (ii) there is disagreement
10 about what the patient's best interest is; and
11
12 Whereas, CDC data shows from 2003-14 at least 143 babies died after being born alive after an
13 abortion procedure, but did not count newborns that survived attempted abortions; and
14
15 Whereas, the number of children that live after an abortion procedure is only reported now by
16 anecdotal reports; and
17
18 Whereas, cited in the Annotations section of the Code of Ethics, "Children Not Meant to Be:
19 Protecting the Interests of the Child When Abortion Results in Live Birth", 6 Quinnipiac Health
20 states in conclusion that "in these situations, abortive parents and physicians should not solely
21 decide the child's best interests."; therefore be it
22
23 RESOLVED, that our American Medical Association amend the current policy right for an
24 abortion to "a woman's right to abortion as only the right to terminate the pregnancy" (Modify
25 Current HOD Policy); and be it further
26
27 RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical
28 care. (New HOD Policy)

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

Received: 4/23/2024

Relevant AMA Policy:

AMA Policy 2.2.4 Treatment Decisions for Seriously Ill Newborns

Making treatment decisions for seriously ill newborns is emotionally and ethically challenging for both parents and health care professionals. Decisions must take into account the newborn's medical needs; the interests, needs, and resources of the family; and available treatment options. Decision makers must also assess whether the choice made for the newborn will abrogate a choice the future individual would want to make for him- or herself, i.e., whether the choice will undermine the child's right to an "open future." Providing information and other resources to support parents or guardians when they must make decisions about their child's care and future is a key responsibility for physicians and other health care professionals.

Decisions not to initiate care or to discontinue an intervention can be emotionally wrenching in any circumstance, but may be particularly so for a seriously ill newborn. Physicians are in a position to help parents, families, and fellow professionals understand that there is no ethical difference between withholding and withdrawing treatment—when an intervention no longer helps to achieve the goals of care or promote the quality of life desired for the patient, it is ethically appropriate to withdraw it.

To help parents formulate goals for their newborn's care and make decisions about life-sustaining treatment on their child's behalf, physicians should:

- a. Inform the parents about available therapeutic options, the nature of available interventions, and their child's expected prognosis with and without treatment.
- b. Help the parents formulate goals for care that will promote their child's best interests in light of:
 - i. the chance that the intervention will achieve the intended clinical benefit;
 - ii. the risks involved with treatment and nontreatment;
 - iii. the degree to which treatment can be expected to extend life;
 - iv. the pain and discomfort associated with the intervention; and
 - v. the quality of life the child can be expected to have with and without treatment.
- c. Discuss the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a given amount of time to determine whether the intervention has led to improvement. Confirm that if the intervention has not achieved agreed-on goals, it may be withdrawn. Physicians should recognize, and help parents appreciate, that it is not necessary to have prognostic certainty to withdraw life-sustaining treatment, since prognostic certainty is often unattainable and may unnecessarily prolong the infant's suffering.
- d. Initiate life-sustaining and life-enhancing treatment when the child's prognosis is largely uncertain.
- e. Adhere to good clinical practice for palliative care when life-sustaining treatment is withheld or withdrawn.
- f. Provide access to counseling services or other resources to facilitate decision making and to enable parents opportunity to talk with others who have had to make similar decisions.
- g. Seek consultation through an ethics committee or other institutional resource when disagreement about the appropriate course of action persists.

AMA Policy 2.2.1 Pediatric Decision Making

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and

parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

- a. Provide compassionate, humane care to all pediatric patients.
- b. Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- c. Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- d. Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- e. Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.
- f. When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
- g. When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
- h. When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-24)

Introduced by: Mississippi

Subject: AMA Executive Vice President

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association (AMA) is the most powerful voice for physicians in
2 the nation; and
3
4 Whereas, the Executive Vice President (EVP) of the AMA is thus a position of extreme
5 importance to the physician community; and
6
7 Whereas, the tradition of our AMA has been to have a physician EVP; and
8
9 Whereas, our AMA should select the most qualified physician leader possible for the EVP
10 position; and
11
12 Whereas, at any given time that best physician leader may be serving or have recently served in
13 the AMA physician leadership; and
14
15 Whereas, physician leaders who are serving or recently served in AMA leadership are
16 sometimes the most knowledgeable and experienced in addressing the current issues facing
17 the House of Medicine; and
18
19 Whereas, many physician leaders serving in the AMA would be extremely qualified candidates
20 for the AMA EVP based on their AMA leadership experience and their own medical practice and
21 medical administration leadership experiences; and
22
23 Whereas, the Mississippi State Medical Association (MSMA) had a similar situation and was
24 able to hire a physician and past President and Chair of the Board of our MSMA as our
25 Executive Director during a difficult time for our organization; and
26
27 Whereas, the MSMA board wanted the ability to hire the best qualified candidate as Executive
28 Director without the restriction even if they had served or were currently serving in a leadership
29 role at MSMA; and
30
31 Whereas, physicians who may be serving or have recently served in the AMA physician
32 leadership as an officer or trustee are currently ineligible for consideration for the AMA EVP
33 position under AMA Code Section B-5.3.6.4 until three years after their AMA service; and
34
35 Whereas, no comparable physician or health care organization has such a strict limitation on
36 who can be considered for their EVP position; therefore be it
37
38 RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties
39 and Privileges Code B-5.3.6.4 as follows:

- 1 ~~No individual who has served as an AMA officer or trustee shall be selected or serve as~~
- 2 ~~Executive Vice President until three years following completion of the term of the AMA office.”~~
- 3 (Modify Bylaws)

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

Received: 4/23/2024

RELEVANT AMA POLICY

Board of Trustees Duties and Privileges. B-5.3

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

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

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

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

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

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

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

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

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

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

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

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

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

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

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-24)

Introduced by: Missouri

Subject: Treatment of Family Members

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, the code of ethics of the American Medical Association (AMA) was written in the 19th
2 century AD; and
3
- 4 Whereas, the practice of medicine has taken giant steps since then in areas of diagnostic
5 testing, medical records recordings, patient safety measures, documentations, verifications,
6 consents, hospitals and outpatients credentialing of surgeons and procedurists, etc.; and
7
- 8 Whereas, concerns about appropriateness of care, indications, and proper training of physicians
9 performing a procedure, or a physician treating any patient has become a legal and ethical
10 process witnessed by office, hospital, and medical facilities' staff including medical and non-
11 medical personnel recording, and reviewing appropriateness of care besides the treating
12 physicians; and
13
- 14 Whereas, multiple documented surveys of specialists and PCPs showed that a large number of
15 these physicians admitted treating family members when they felt comfortable and confident
16 they can provide the best care for them; and
17
- 18 Whereas, a much larger percentages of plastic, head and neck surgeons, dermatologists, have
19 admitted treating their family members; and
20
- 21 Whereas, the current code of ethics, as it is currently written, sadly label these physicians acts
22 as unethical; and
23
- 24 Whereas, many hospitals, and surgery centers have "discovered" lately this part of the code of
25 ethics, and started enforcing it, therefore forcing the physicians to seek other venues to treat
26 family members; and
27
- 28 Whereas, rendering care or performing procedures outside approved facilities such as an
29 uncredited office procedure room or un-accredited other facilities endanger the life and well-
30 being of the patients; and
31
- 32 Whereas, physicians ultimate concern is their patient's safety and wellbeing whether the patient
33 is a family member, a staff person, a friend or none of these; therefore be it
34
- 35 RESOLVED, that our American Medical Association asks CEJA to review and revise the current
36 code of ethics as it relates to treating family members (Directive to Take Action); and be it
37 further
38
- 39 RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim
40 meeting I-24. (Directive to Take Action)

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-24)

Introduced by: American Association of Public Health Physicians

Subject: AMA Supports a Strategy for Eliminating Nuclear Weapons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, AMA policies concerning weapons, which were modified last in 2015, voice clear
2 “opposition to nuclear war” (Ref 1) and support for “the elimination by all nations of nuclear
3 weapons and other weapons of mass and indiscriminate destruction” (Ref 2); and
4

5 Whereas, millions have been sickened or killed by nuclear weapons testing around the world
6 since 1945, yet the United Nation’s Comprehensive Nuclear Test Ban Treaty, adopted by the
7 UN General Assembly in 1996 and ratified by 178 countries as of March 2024, has failed to
8 enter into force because the United States and other nuclear weapons possessing countries
9 have not ratified it and because, ominously, Vladimir Putin’s government withdrew its ratification
10 in 2023 (Ref 3); and
11

12 Whereas, AMA policy supports a “comprehensive nuclear test ban” and encourages the US
13 Government to “to continue the process of bilateral and verifiable nuclear arms reduction”, (Ref
14 4 & 5) but that process has stalled; and
15

16 Whereas, seventy-six years after the 1945 bombs that killed hundreds of thousands of innocent
17 civilians in Japan, the United Nation’s Treaty of the Prohibition of Nuclear Weapons at last
18 became international law in 2021, though the Treaty is not ratified yet by any country that
19 possesses nuclear weapons, (Ref 6); and
20

21 Whereas, the US government plans to spend \$1.7-3 trillion over the next thirty years to update
22 its thousands of nuclear bombs and delivery systems, money that the concepts of intersectional
23 justice (Ref 7) dictate should be better spent on healthcare, education, housing and other
24 needs; and
25

26 Whereas, a strategy towards implementing the Treaty on the Prohibition of Nuclear Weapons
27 has been enunciated (Ref 8); and
28

29 Whereas, this strategy has been endorsed by hundreds of local governments, civil society
30 organizations, and medical organizations, including the Maine Medical Association, American
31 Public Health Association, Physicians for Social Responsibility, and Union of Concerned
32 Scientists, (Ref 9); and
33

34 Whereas, the ongoing conflicts in Ukraine, the Middle East, and the Indo-Pakistani region
35 involving nuclear weapons possessing countries are raising the risk of an intentional or
36 accidental nuclear war with devastating health consequences; therefore be it
37

38 RESOLVED, that our American Medical Association calls for the United States and the other
39 nuclear weapons states to sign and ratify the United Nations Treaty on the Prohibition of

1 Nuclear Weapons and to pursue good-faith negotiations on effective measures relating to the
2 cessation of the nuclear arms race (Directive to Take Action); and be it further

3
4 RESOLVED, that our AMA calls for the United States to renounce the option to be the first
5 country to use nuclear weapons (“first use”) during a conflict (Directive to Take Action); and be it
6 further

7
8 RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely
9 the President, are required to approve a nuclear attack, while still allowing a swift response
10 when needed (New HOD Policy); and be it further

11
12 RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire
13 nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of
14 nuclear weapons and delivery systems. (Directive to Take Action)

15
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/24/2024

REFERENCES

1. H-520.999 Opposition to Nuclear War
The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.
2. H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction
The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.
3. https://en.wikipedia.org/wiki/Comprehensive_Nuclear-Test-Ban_Treaty Accessed 3.28.2024
4. H-520.994 Nuclear Test Ban
The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban
5. D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War
Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.
Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.
6. <https://disarmament.unoda.org/wmd/nuclear/tpnw/> Accessed 3.28.2024
7. Intersectional Justice: <https://psr.org/wp-content/uploads/2023/11/intersectional-justice.pdf>. Accessed 3.28.2024
8. Back from the Brink. Our five policy solution. Available at: <https://www.preventnuclearwar.org/our-five-policy-solutions/>. Accessed 3.28.2024
9. APHA Policy 20209: <https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2021/01/13/Toward-a-World-Free-of-Nuclear-Weapons> . Accessed 3.28.2024

RELEVANT AMA POLICY

H-520.999 Opposition to Nuclear War

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.

Citation: (Sub. Res. 82, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: Res. 524, A-15)

H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction

The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.

Res. 617, I-96 Reaffirmed: CLRPD Rep. 2, A-06 Reaffirmed: Res. 524, A-15

H-520.994 Nuclear Test Ban

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban.

Res. 90, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: Res. 524, A-15

D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War

1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.

2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.

Res. 436, A-05 Appended: Res. 524, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-24)

Introduced by: Barbara L. McAneny, MD

Subject: Consolidated Health Care Market

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the American Medical Association has long warned the nation about the problems
2 that can be associated with a consolidated health care market and has opposed insurance
3 company mergers; and
4

5 Whereas, Optum acquired Change Health over the objections of the Federal Trade
6 Commission; and
7

8 Whereas, on February 21, 2024, Optum and Change Health suffered a ransomware attack and
9 shut down all operations, including the electronic claims submission, electronic remittance, prior
10 authorization and documentation of patient eligibility; and
11

12 Whereas, across the country, medical practices, hospitals, pharmacies and many other health
13 care businesses had their revenue cycle disrupted, and cash flow interrupted, putting their
14 economic viability at risk; and
15

16 Whereas, Optum and its parent company United Health Group continued to collect premiums
17 and had the opportunity to retain significant amounts of money as no claims were being paid,
18 and therefore had the opportunity to collect interest and investment gains on money that should
19 have been paid to practices and other entities, raising the question of unjust enrichment; and
20

21 Whereas, Optum is the largest employer of physicians and has acquired practices when the
22 ransomware disruption made those practices unable to survive without acquisition; and
23

24 Whereas, even the practices that survive will have ongoing damages including but not limited to
25 denials related to giving therapy when it was impossible to obtain prior authorization, from using
26 lines of credit and having to pay interest, from having billing departments and others work
27 overtime to submit claims, to losing key employees from inability to make payroll; and
28

29 Whereas, oncology practices were particularly hard hit because of the need to purchase
30 chemotherapy without being able to be paid for the chemotherapy and are being charged late
31 payments for those purchases; and
32

33 Whereas, the AMA has a long history of defending practices against unfair business practices
34 by insurance companies and their subsidiaries; therefore be it
35

36 RESOLVED, that our American Medical Association investigate the possibility of filing a class
37 action lawsuit against Optum, United Health Group and Change Health to recoup the damages
38 from the disruption caused by the breach, and to distribute the unfair enrichment profits made
39 by Optum et al to the practices whose retained payments allowed them to generate interest and
40 investment profits (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of
- 2 the breach and determine if the independence of those practices can be resurrected, and if not,
- 3 if damages are due to the physician owners of the acquired practices. (Directive to Take Action)

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-24)

Introduced by: Resident and Fellow Section

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, current AMA policy includes gendered language such as “mother” and “pregnant
2 woman” when discussing families and persons in need of obstetric and gynecologic care such
3 as in H-20.917, H-320.954, H-420.950, H-420.962, H-420.969, and more; and
4

5 Whereas, the Human Rights Campaign (HRC) definition of “family” when used in hospital
6 visitation policy is stated as: “‘Family’ means any person(s) who plays a significant role in an
7 individual’s life. This may include a person(s) not legally related to the individual. Members of
8 ‘family’ include spouses, domestic partners, and both different-sex and same-sex significant
9 others. ‘Family’ includes a minor patient’s parents, regardless of the gender of either parent.”¹;
10 and
11

12 Whereas, in 2022 the American College of Obstetricians and Gynecologists (ACOG) published
13 a policy statement stating “To be inclusive of women and all patients in need of obstetric and
14 gynecologic care, ACOG will move beyond the exclusive use of gendered language and
15 definitions”¹; and
16

17 Whereas, the World Professional Association for Transgender Health (WPATH)’s *Standards of*
18 *Care - version 8*, published in 2022, includes guideline 1.2 which states that “We recommend
19 health care professionals use language in health care settings that uphold the principles of
20 safety, dignity, and respect”³; and
21

22 Whereas, AMA policy H-65.942, adopted in June 2023, strongly encourages the use of gender-
23 neutral language supports the use of gender-neutral language in AMA policies and
24 communications, but as written this policy does not apply to other resources the AMA creates
25 and distributes; therefore be it
26

27 **RESOLVED**, that our American Medical Association review and update the language used in
28 AMA policy and other resources and communications to ensure that the language used to
29 describe families and persons in need of obstetric and gynecologic care is inclusive of all
30 genders and family structures. (Directive to Take Action)

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

Received: 4/24/2024

REFERENCES:

1. The Human Rights Campaign Foundation. LGBTQ+ inclusive definitions of family. HRC Foundation. <https://www.thehrcfoundation.org/professional-resources/lgbtq--inclusive-definitions-of-family>. Accessed April 17, 2023.
2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>. Published February 2022. Accessed April 17, 2023.

3. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

Relevant AMA Policy:

HIV/AIDS and Substance Abuse H-20.903

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918

In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

- (1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.
- (2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
- (3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.
- (4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.

2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.

3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.

4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. [Res. 428, A-16]

Reducing Lead Poisoning H-60.924

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current

weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level $>5 \mu\text{g/dL}$ ($>50 \text{ ppb}$) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level $>1 \mu\text{g/dL}$ (10 ppb).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above $1 \mu\text{g/dL}$ (10 ppb).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.

2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. [Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

Humanitarian and Medical Aid Support to Ukraine D-65.984

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

Addiction and Unhealthy Substance Use H-95.976

Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

- (1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
- (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
- (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
- (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
- (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
- (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
- (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
- (8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. [BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19]

Mercury and Fish Consumption: Medical and Public Health Issues H-150.947

AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. [CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15]

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages

public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

Accommodating Lactating Mothers Taking Medical Examinations H-295.861

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

Protecting Trainees' Breastfeeding Rights D-310.950

Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. [Res. 302, I-16]

Post-Partum Hospital Stay and Nurse Home Visits H-320.954

The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of

the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected. [Res. 209, A-18; Modified: Res. 520, A-19]

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. [Res. 102, A-12; Modified: Res. 503, A-17]

Shackling of Pregnant Women in Labor H-420.957

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

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

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

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

Fetal Alcohol Syndrome Educational Program H-420.964

Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Legal Interventions During Pregnancy H-420.969

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:

- (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
- (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
- (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
- (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
- (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
- (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992

Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. [Res. 504, A-17]

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. [Issued: 2016]

Supporting the Use of Gender-Neutral Language H-65.942

Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies¹ internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. [Res. 602, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-24)

Introduced by: Mississippi

Subject: Ethical Pricing Procedures that Protect Insured Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, healthcare organizations that provide direct care (such as clinics, pharmacies,
2 hospitals, and the like) are operating on increasingly small profit margins and many are on the
3 brink of bankruptcy; and
4
- 5 Whereas, the health insurance industry as a whole is consistently posting significant profits; and
6
- 7 Whereas, many health insurance companies are publicly traded and, thusly, their directors hold
8 a fiduciary duty to their shareholders to make decisions based on the company's best financial
9 interests for the end of increased profit margins without sufficient regard to the beneficiaries (the
10 insureds) that pay for their services; and
11
- 12 Whereas, the process of pricing medications for consumers is increasingly complicated,
13 involving many middlemen and questionable practices that are not disclosed to the public under
14 the guise of "proprietary means"; and
15
- 16 Whereas, this complicated process has been manipulated by health insurance companies,
17 pharmaceutical manufacturers, pharmacy benefit managers, and other stakeholders to
18 negotiate terms that offer benefits for themselves without sufficient regard to the best interests
19 of their insured patients; and
20
- 21 Whereas, under the current system, insured patients pay a monthly premium in good faith
22 believing that their health insurer will arrange for medications to be bought by them (the
23 insureds) at a lower cost point than could otherwise be achieved without insurance or some
24 other non-paid service; and
25
- 26 Whereas, the current system has betrayed the aforementioned good faith of the insured patients
27 by utilizing a pricing process that results in higher prices to the patient for many medications
28 than could be achieved without insurance coverage (cash price) or with the aid of a free
29 "discount card" (such as GoodRX); and
30
- 31 Whereas, this betrayal of the insured patients' good faith represents a flaw of the system that is
32 woefully unethical and should be identified as such by insureds as well as their advocates (the
33 House of Medicine) and should be addressed by lawmakers for consumer and patient
34 protection; and
35
- 36 Whereas, physicians are a cornerstone in the House of Medicine and, by nature of their
37 profession, are fierce patient advocates, safeguarding the patient's best interests; and
38
- 39 Whereas, the American Medical Association (AMA) is the most prominent and powerful unified
40 voice of Physicians; therefore be it

1 RESOLVED, that our American Medical Association advocate for policies that limit the cost of a
2 medication to an insured patient with medication coverage to the lower range of prices that a
3 non-covered patient can achieve at cash price either before or after application of a non-
4 manufacturer's free discount card (such as GoodRx) (Directive to Take Action); and be it further
5

6 RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders
7 describing the ethical dilemma of the medication pricing process and how it adversely affects
8 insured patients. (Directive to Take Action)
9

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-24)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, each year 3.6 million¹ individuals give birth in the United States and 3 million people
2 are lactating; and
3
4 Whereas, 70% of pregnant and lactating people² take some kind of medication when they are
5 pregnant or lactating; and
6
7 Whereas, pregnant and lactating people are generally excluded in clinical research³, there is a
8 dearth of data about the appropriate safety, dosage, and efficacy of most medical interventions
9 in pregnant and lactating individuals; and
10
11 Whereas, the lack of data results in patients and clinicians choosing to (a) forego an intervention
12 which may result in harm from an un(der) treated condition or (b) use an intervention which may
13 carry an uncertain risk of harm for an unknown potential benefit; and
14
15 Whereas, lack of access to research exacerbates health inequities in pregnant and lactating
16 individuals⁴; and
17
18 Whereas, the harm from excluding pregnant individuals from clinical research was very
19 apparent during the COVID-19 pandemic and contributed to vaccine hesitancy and resulted in
20 unnecessary and avoidable maternal and infant mortality and morbidity^{5,6,7}; and
21
22 Whereas, recent initiatives from the White House⁸, National Institutes of Health⁹, and the
23 National Academies of Science, Engineering, and Medicine¹⁰ have emphasized the need for
24 further research in pregnant and lactating individuals; and
25
26 Whereas, the American College of Obstetricians and Gynecologists¹¹, National Academies of
27 Science, Engineering, and Medicine¹⁰, and the U.S. Department of Health and Human Services
28 have moved from an overly protectionist ethic that prioritizes minimization of fetal risk to one
29 that recognizes the scientific, legal, and ethical complexities of research including the risks to
30 the pregnant/lactating individual, fetus, and/or neonate of NOT doing research; and
31
32 Whereas, the HHS Task Force on Research Specific to Pregnant Women and Lactating Women
33 released detailed recommendations, along with an implementation plan, to protect pregnant and
34 lactating individuals through research, rather than from research^{12,13}; and
35
36 Whereas, as this national policy discussion unfolds, the ethical guidance of our profession must
37 undergird this discussion; and

1 Whereas, the existing Code of Medical Ethics Opinion 7.3.4 Maternal-Fetal Research extracts
2 content from both the Code modernization process of 2016 with foundational original material
3 stemming from the “Medical applications of fetal tissue transplantation” opinion passed in 1989;
4 and

5
6 Whereas, much in women’s health, research infrastructure, ethical frameworks, and liability
7 landscape has changed since 1989 and the ethics of research in lactation is not discussed in
8 the Code; therefore be it

9
10 RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs
11 update its ethical guidance on research in pregnant and lactating individuals. (Directive to Take
12 Action)
13

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

Received: 4/24/2024

REFERENCES

1. Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., Valenzuela, C. P., & Division of Vital Statistics. 2023. Births: Final Data for 2021. <https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-01.pdf>.
2. Centers for Disease Control. 2024. Research. Medicine and Pregnancy. <https://www.cdc.gov/pregnancy/meds/treatingfortwo/research.html>.
3. National Academies of Sciences, Engineering, and Medicine. 2023. Inclusion of Pregnant and Lactating Persons in Clinical Trials: Proceedings of a Workshop. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26790>.
4. Hill, L., S. Artiga, and U. Ranji. 2022. Racial disparities in maternal and infant health: Current status and efforts to address them. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/>.
5. Kasehagen L, Byers P, Taylor K, et al. 2021. COVID-19–Associated Deaths After SARS-CoV-2 Infection During Pregnancy — Mississippi, March 1, 2020–October 6, 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:1646–1648. DOI: <http://dx.doi.org/10.15585/mmwr.mm7047e2>.
6. Man, O.M., Azamor, T., Cambou, M.C. et al. 2024. *Respiratory distress in SARS-CoV-2 exposed uninfected neonates followed in the COVID Outcomes in Mother-Infant Pairs (COMP) Study*. *Nat Commun* 15,399. <https://doi.org/10.1038/s41467-023-44549-5>.
7. Razzaghi H, Meghani M, Pingali C, et al. 2021. *COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 8, 2021*. *MMWR Morb Mortal Wkly Rep* 2021;70:895–899. https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e2.htm?s_cid=mm7024e2_w.
8. The White House. 2024. *Executive Order on Advancing Women’s Health Research and Innovation*. <https://www.whitehouse.gov/briefing-room/presidential-actions/2024/03/18/executive-order-on-advancing-womens-health-research-and-innovation/>.
9. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH , HHS. 2023. *Task Force on Research Specific to Pregnant Women and Lactating Women (PRGLAC) (2017-2021)*. <https://www.nichd.nih.gov/about/advisory/PRGLAC>.
10. National Academies of Sciences, Engineering, and Medicine. 2024. *Advancing Clinical Research with Pregnant and Lactating Populations: Overcoming Real and Perceived Liability Risks*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/27595>.
11. American College of Obstetricians and Gynecologists. 2015. *Ethical considerations for including women as research participants*. Committee Opinion No. 646. *Obstet Gynecol* 2015;126:e100–7. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/11/ethical-considerations-for-including-women-as-research-participants>.
12. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH , HHS. 2018. *Task Force on Research Specific to Pregnant Women and Lactating Women. Report to Secretary, Health and Human Services Congress*. https://www.nichd.nih.gov/sites/default/files/2018-09/PRGLAC_Report.pdf.
13. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, HHS. 2020. *Task Force on Research Specific to Pregnant Women and Lactating Women. Report Implementation Plan To the Secretary, Health and Human Services*. https://www.nichd.nih.gov/sites/default/files/inline-files/PRGLAC_Implement_Plan_083120.pdf.

RELEVANT AMA POLICY

7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-24)

Introduced by: New England

Subject: The Preservation of the Primary Care Relationship

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, large health systems are restricting access to specialty care unless patients change
2 their primary care physician to a physician, physician associate (PA), or nurse practitioner (NP)
3 employed by their system, resulting in the extreme disruption of well-established patient
4 physician relationships; and

5
6 Whereas, the Institute of Medicine has declared that continuity is foundational to the
7 effectiveness of the patient physician relationship in primary care, with decades of research
8 concluding that coordination of care is essential to building a trusting relationship¹; and

9
10 Whereas, the Commonwealth Fund and the Agency for Healthcare Research and Quality
11 underscore the critical role of high-quality primary care in enhancing health system
12 effectiveness, advocating for increased financial investment, shifting to hybrid or capitated
13 payment approaches, and emphasizing the adoption of patient-centered medical homes to
14 address existing challenges and ensure accessibility, efficiency, and quality in healthcare^{2,3}; and

15
16 Whereas, maintaining outpatient continuity with a primary care physician reduces emergency
17 department use and hospitalizations, lowers costs, and increases patient and physician
18 satisfaction, while discontinuity is linked to higher post discharge costs and readmission rates^{4,5};
19 and

20
21 Whereas, value-based care contracting financially incentivizes systems to “capture” large
22 numbers of patients which has led to the practice of large health systems coercing patients to
23 abandon their primary care physician of choice, establishing with one of their employed
24 physicians, NPs or PAs in order to access specialty care; and

25
26 Whereas, hospital consolidations have also been scrutinized for boosting costs, narrowing
27 access, and potentially impacting care quality, where these consolidations can lead to increased
28 prices and may not necessarily improve the quality of care patients receive⁶; and

29
30 Whereas, due to national and regional differences in access to both specialty and primary care,
31 in addition to variations in the expansiveness of large health care systems, there is a lack of
32 transparency and data on the impact of these restrictive practices and necessitates further
33 study⁷; and

34
35 Whereas, there is a current crisis in healthcare with limited access to primary care and certain
36 specialties, further, given this limited access, it is important that patients are able to obtain care
37 across networks, and limiting this access harms both the patients and the physicians; and

1 Whereas, CEJA Report 1-A-01, The Patient-Physician Relationship, states that “The medical
2 profession must strive to preserve the trust patients hold in their physicians. It cannot abandon
3 ethical standards to economic force”⁸; therefore be it
4

5 RESOLVED, that our American Medical Association opposes health systems requiring patients
6 to switch to primary care physicians within a health system in order to access specialty care
7 (New HOD Policy); and be it further
8

9 RESOLVED that our AMA requests the Council on Ethical and Judicial Affairs review the ethical
10 implications of health systems requiring patients to change to primary care clinicians employed
11 by their system to access specialists (Directive to Take Action); and be it further
12

13 RESOLVED, that our AMA advocates for policies that promote patient choice, ensure continuity
14 of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare
15 system pressures or economic incentives. (Directive to Take Action)

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

Received: 5/7/2024

REFERENCES

1. "Institute of Medicine (US) Committee on the Future of Primary Care, Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996."
2. Evidence-Based Strategies for Strengthening Primary Care in the U.S. www.commonwealthfund.org. Published August 5, 2022. <https://www.commonwealthfund.org/blog/2022/evidence-based-strategies-strengthening-primary-care-us>
3. Bazemore A, Grunert T. Sailing the 7C's: Starfield Revisited as a Foundation of Family Medicine Residency Redesign. Family Medicine. Published online May 6, 2021. doi:<https://doi.org/10.22454/fammed.2021.383659>
4. Goodwin JS. Continuity of Care Matters in All Health Care Settings. JAMA Network Open. 2021;4(3):e213842. doi:10.1001/jamanetworkopen.2021.3842
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x
6. US D Department of Health and Human Services. Access to Health Services. health.gov. Published 2020. <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services>
7. Naylor KB, Tootoo J, Yakusheva O, Shipman SA, Bynum JPW, Davis MA. Geographic variation in spatial accessibility of U.S. healthcare providers. PLoS One. 2019;14(4):e0215016. Published 2019 Apr 9. doi:10.1371/journal.pone.0215016
8. Opinion 1.1.1 Patient-Physician Relationships. Accessed March 11, 2024. https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.%20Patient-physician%20relationships--background%20reports_0.pdf

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901

Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Disease Management and Demand Management H-285.944

The AMA strongly encourages health insurance plans and managed care organizations that provide disease management to involve the patient's current primary or principal care physician in the disease management process as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings.

1.1.1 Patient-physician relationships--background reports_0.pdf (ama-assn.org)

Relevant AMA Correspondences

RE: The Acquisition of Aetna, Inc. by CVS Health Corporation 2018, to the United States Department of Justice

We are writing to provide our views regarding the proposed merger of CVS Health Corporation (CVS), the largest retail pharmacy chain and specialty pharmacy in the U.S. and one of the two largest pharmacy benefit managers (PBM), and Aetna, Inc. (Aetna), the third largest U.S. health insurer. The AMA has studied this merger, an analysis that started almost as soon as the merger was officially announced. The AMA has sought the views of prominent health economists, health policy and antitrust experts—some of whom testified in a California Department of Insurance hearing on this merger. After very carefully considering this merger over the past months, the AMA has come to the conclusion that this merger would likely substantially lessen competition in many health care markets, to the detriment of patients. Accordingly, based on the mutually confirming analyses and conclusions presented by the nationally recognized experts and other experts, as well as extensive research, the AMA is now convinced that the proposed CVS-Aetna merger should be blocked.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-24)

Introduced by: New England

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and
3 social determinants of health — to eliminate disparities in health and health care¹; and
4
- 5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is
6 essential to optimizing health care access and the quality of patient care; and
7
- 8 Whereas, many barriers remain and unique challenges persist for some diverse groups
9 attempting to enter the medical field and successfully matriculate through the profession of
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and
11
- 12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%
13 identified as Hispanic, and ~5.0% identified as Black or African American²; and
14
- 15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to
18 increase by 26% by 2030^{3,4}; and
19
- 20 Whereas, black people account for roughly 13 percent of the US population, they make up only
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These
23 representational disparities have not changed appreciably in decades;^{3,4} and
24
- 25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates
26 of remedial intervention and dismissal from their programs than their White counterparts, thus
27 leading to concerns of over-policing in medical education; and
28
- 29 Whereas, over-policing in education begins as early as primary school and continues through
30 high school, college, medical education, and into the workforce. In graduate medical
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in
32 the residency selection process;⁵ and
33
- 34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly
35 20% of those who were dismissed in 2015;⁷and
36
- 37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms
38 of depression and anxiety among minority students, residents and physicians. This often leads

1 to reducing practice hours or leaving medicine, creating even greater workforce
2 disparities;⁵ therefore be it

3
4 RESOLVED, that our American Medical Association further study and track the prevalence of
5 attending physicians' and trainees' dismissals and remedial interventions, based on race,
6 gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities
7 (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA engage stakeholders to study and report back how to effectively
10 support underrepresented groups in medicine to level the playing field for those most affected
11 by bias and historical harms (Directive to Take Action); and be it further

12
13 RESOLVED, that our AMA work with stakeholders to make recommendations on a review and
14 appeals process that will enable physicians and trainees to receive a fair and equitable due
15 process in defense of alleged shortcomings. (Directive to Take Action)

16
Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

1. U.S. Department of Health and Human Services. (n.d.). Achieving health equity. Healthy People 2030. Retrieved from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030#:~:text=Achieving%20health%20equity%20requires%20valuing,in%20health%20and%20health%20care>
2. Association of American Medical Colleges. (2018). Percentage of All Active Physicians by Race/Ethnicity: 2018. Retrieved from <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018#:~:text=Among%20active%20physicians%2C%2056.2%25%20identified,subgroup%20after%20White%20and%20Asian>
3. Johnson, T. (2023, March 23). Analysis: Racism in academic medicine is hindering progress toward health equity. California Health Report. Retrieved from <https://www.calhealthreport.org/2023/03/23/analysis-racism-in-academic-medicine-is-hindering-progress-toward-health-equity/>
4. University of California, Los Angeles. (n.d.). Proportion of Black Physicians Shows Little Change. Retrieved from <https://newsroom.ucla.edu/releases/proportion-black-physicians-little-change>
5. Health Care News. (n.d.). Dismantling the overpolicing of Black residents. Retrieved from <https://hcn.health/hcn-trends-story/dismantling-the-overpolicing-of-black-residents/>
6. Commonwealth Fund. (2024, February). Revealing disparities: Health care workers' observations. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/revealing-disparities-health-care-workers-observations>
7. Ryan, P. (2022, June 20). Black doctors forced out of training programs at far higher rates than white residents. STAT. Retrieved from <https://www.statnews.com/2022/06/20/black-doctors-forced-out-of-training-programs-at-far-higher-rates-than-white-residents/>
8. Ryan, P. (2022, June 21). What will it take to level the playing field for Black residents? STAT. Retrieved from <https://www.statnews.com/2022/06/21/what-will-it-take-to-level-the-playing-field-for-black-residents/>
9. Jha, A. K. (2022). Structural racism and inequity in medicine. *New England Journal of Medicine*, 386(14), 1353-1356. doi: 10.1056/NEJMp2304559
10. Wadhwa, R. K., & Yeh, R. W. (2022). Addressing racism in medicine — toward a more equitable future. *New England Journal of Medicine*, 386(18), 1743-1746. doi: 10.1056/NEJMp2306195

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed

care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16 Modified: Res. 009, A-21 Modified: CME Rep. 5, A-21

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

Res. 325, A-03 Appended: CME Rep. 6, A-11 Modified: CME Rep. 3, A-13 Appended: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Appended: Res. 319, A-22 Modified: Res. 319, A-23

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area

Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14

Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18

Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19

Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23

American Medical Association House of Delegates

Resolution: 016
(A-24)

Introduced by: New York

Subject: Guiding Principles for the Healthcare of Migrants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, there has been a recent increase in migrants and asylum seekers in the United States
2 that has garnered New York City, New York State and National media attention ¹; and
3
4 Whereas, this recent increase in migrants and asylum seekers has overwhelmed multiple areas
5 of the United States, including southern border states such as Texas and Arizona, and has
6 resulted in their coordinated transportation to cities that have “right to shelter” laws, such as
7 New York City, Chicago, Denver and Washington D.C. ^{2,3}, and
8
9 Whereas, from April 2022 to December 2023, more than 150,000 migrants have arrived in New
10 York City;¹ and
11
12 Whereas, the Mayor of the City of New York declared an “Asylum Seeker State of Emergency”
13 on 10/7/22, calling for increased aid from State and Federal governments⁴; and
14
15 Whereas, the 2022-2023 New York City budgets did not account for this recent increase in
16 migrants and asylum seekers, yet New York City has attempted to divert adequate resources to
17 the New York City Health and Hospital System, which operates the Humanitarian Emergency
18 Response and Relief Centers (HERRCs) which process the intake, screening, shelter,
19 healthcare and other needs of migrants and asylum seekers ⁵; and
20
21 Whereas, the diversion of funds from the New York City budget to HERRCs and other
22 associated costs of the recent increase in migrants and asylum seekers has resulted in a
23 decreased funding of other New York City municipal services, such as public libraries, public
24 schools and law enforcement⁶; and
25
26 Whereas, New York State has declared a Disaster Emergency via Executive Order No. 28.7 in
27 response to the recent increase in migrants and asylum seekers in New York State ⁷, and
28
29 Whereas, despite a \$1 Billion addition to the New York State 2024 Budget allocated for
30 response for migrants and asylum seekers, as well as mobilization of 1,500 National Guard
31 Members and an Executive Order mobilizing additional resources, the New York State Governor
32 is requesting additional support and resources from the Federal Government, including FEMA,
33 the U.S. Department of Defense, and the National Parks Service ^{8, 9, 10}; and
34
35 Whereas, New York City has become so financially overwhelmed with the recent increase in
36 migrants and asylum seekers that it has requested discontinuation of its “right to shelter”
37 statutes, and has reverted to litigating bus transportation companies for costs associated with
38 the healthcare and housing of asylum seekers they have brought ^{11, 12}; and

1 Whereas, Federal legislators are considering massive overhauls to immigration policy, but only
2 at the expense of continued financial aid in the international conflict between Russia and
3 Ukraine ¹³; and
4

5 Whereas, having adequate policy regarding the guiding principles of the healthcare for migrants
6 and asylum seekers will allow organized medicine groups to adequately respond to future
7 legislation or executive actions regarding the present migration crisis and future migration
8 issues; and
9

10 Whereas, the First District Branch of MSSNY has “RESOLVED, that the First District Branch will
11 collaborate together to write a resolution ... to advocate for increased federal funding, and other
12 federal solutions, to address the public health needs of the recent 2023 increase in asylum-
13 seeking migrants.”, but has no other standing policy on migrants and asylum seekers; and
14

15 Whereas, the Medical Society of the State of New York does not have any present relevant
16 policy regarding providing healthcare for migrant and asylum seekers, and
17

18 Whereas, the American Medical Association policy D-350.975 “Immigration Status is a Public
19 Health Issue” does recognize “immigration status is a public health issue” and “will support the
20 development and implementation of public health policies and programs that aim to improve
21 access to healthcare and minimize systemic health barriers for immigrant communities”, and
22 AMA policy H-350.957 “Addressing Immigrant Health Disparities” addresses a limited scope of
23 issues related to the healthcare of migrants, without reference to many important principles and
24 priorities as identified by the World Health Organization ^{14, 15, 16, 17}; and
25

26 Whereas, while the current migrant crisis being faced in the United States is causing recent
27 local, state and national attention to this issue, other groups dedicated to the study and policy
28 development of the healthcare of migrants at the international level report that this is indeed a
29 part of a larger global migration trend, with the World Health Organization noting that from “2000
30 - 2017, the total number of international migrants rose from 173 million to 258 million, an
31 increase of 49%” ¹⁶; and
32

33 Whereas, migrants face many unique health challenges and vulnerabilities including but not
34 limited to; inadequate access to healthcare, increased need for mental health services,
35 inadequate disease prevention, inadequate provision of care, lack of financial protection,
36 discrimination, language and cultural barriers, increased risk of encountering communicable
37 diseases, poor access to vaccination, inadequate continuity of care, inadequate health record
38 portability, food insecurity, malnutrition, sexual and gender-based violence including abuse and
39 trafficking and unsafe work conditions ¹⁶, therefore be it
40

41 RESOLVED, that our American Medical Association advocate for the development of adequate
42 policies and / or legislation to address the healthcare needs of migrants and asylum seekers in
43 cooperation with relevant legislators and stakeholders based on the following guiding principles,
44 adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the
45 “Colombo Statement” (Directive to Take Action); and be it further
46

47 RESOLVED, that our AMA recognizes that migration status is a social determinant of health
48 (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms the importance of multi-sectoral coordination and inter-
2 country engagement and partnership in enhancing the means of addressing health aspects of
3 migration (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA recognizes that the enhancement of migrants' health status relies on
6 an equitable and non-discriminatory access to and coverage of health care and cross-border
7 continuity of care at an affordable cost avoiding severe financial consequences for migrants, as
8 well as for their families (New HOD Policy); and be it further
9

10 RESOLVED, that our AMA recognizes that investment in migrant health provides positive
11 dividends compared to public health costs due to exclusion and neglect, and therefore
12 underscore the need for financing mechanisms that mobilize different sectors of society,
13 innovation, identification and sharing of good practices in this regard, and be it further
14

15 RESOLVED, that our AMA recognizes that the promotion of the physical and mental health of
16 migrants as defined by the following select objectives from the World Health Organization's
17 72nd World Health Assembly, Global action plan on promoting the health of refugees and
18 migrants, 2019-2023, is accomplished by
19

- 20 1. Ensuring that essential components, such as vaccination of children and adults and the
21 provision of health promotion, disease prevention, timely diagnosis and treatment,
22 rehabilitation and palliative services for acute, chronic and infectious diseases, injuries,
23 mental and behavioral disorders, and sexual and reproductive health care for women,
24 are addressed.
25
- 26 2. Improving the quality, acceptability, availability and accessibility of health care services,
27 for instance by overcoming physical, financial, information, linguistic and other cultural
28 barriers, with particular attention to services for chronic conditions and mental health,
29 which are often inadequately addressed or followed up during the migration and
30 displacement process, and by working to prevent occupational and work-related
31 diseases and injuries among migrant workers and their families by improving the
32 coverage, accessibility and quality of occupational and primary health care services and
33 social protection systems.
34
- 35 3. Ensuring that the social determinants of migrants' health are addressed through joint,
36 coherent multisectoral actions in all public health policy responses, especially ensuring
37 promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible
38 migration and mobility of people, including through implementation of planned and well-
39 managed migration policies, as defined in the Sustainable Development Goals of the
40 United Nations.
41
- 42 4. Ensuring that information and disaggregated data at global, regional and country levels
43 are generated and that adequate, standardized, comparable records on the health of
44 migrants are available to support policy-makers and decision-makers to develop more
45 evidence-based policies, plans and interventions.
46
- 47 5. Providing accurate information and dispelling fears and misperceptions among migrant
48 and host populations about the health impacts of migration and displacement on migrant
49 populations and on the health of local communities and health systems. (New HOD
50 Policy)

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

Received: 5/8/2024

REFERENCES

1. New York Times. (2022). NYC Migrant Crisis Explained. Retrieved from <https://www.nytimes.com/article/nyc-migrant-crisis-explained.html>
2. Associated Press. (2022). Biden, Chicago Mayor Lightfoot Discuss Texas Immigration. Retrieved from <https://apnews.com/article/biden-chicago-lori-lightfoot-texas-immigration-1b5892758ea8a350198db55b9295ba65>
3. NBC News. (2022). Texas Gov. Greg Abbott Divides Democrats on Immigration and Migrant Busing. Retrieved from <https://www.nbcnews.com/politics/politics-news/texas-gov-greg-abbott-divided-democrats-immigration-migrant-busing-rcna128815>
4. City of New York. (2022). Mayor Eric Adams Declares Asylum Seeker State of Emergency. Retrieved from <https://www.nyc.gov/office-of-the-mayor/news/729-22/transcript-mayor-eric-adams-declares-asylum-seeker-state-emergency-calls-urgent-aid-from>
5. Office of the State Comptroller. (2024). Review of the Financial Plan of The City of New York. Retrieved from <https://www.osc.ny.gov/files/reports/osdc/pdf/report-4-2024.pdf>
6. New York Times. (2023). NYC Budget Cuts Impact on Schools, Police, and Trash Collection. Retrieved from <https://www.nytimes.com/2023/11/16/nyregion/nyc-budget-cuts-schools-police-trash.html>
7. Office of the Governor of New York. (2022). Executive Order No. 287: Declaring Disaster Emergency in the State of New York. Retrieved from <https://www.governor.ny.gov/executive-order/no-287-declaring-disaster-emergency-state-new-york>
8. Office of the Governor of New York. (2022). Title 42 Expires: Governor Hochul Issues Executive Order Providing State and Municipalities. Retrieved from <https://www.governor.ny.gov/news/title-42-expires-governor-hochul-issues-executive-order-providing-state-and-municipalities>
9. Office of the Governor of New York. (2022). Governor Hochul Announces Highlights of FY 2024 Executive Budget. Retrieved from <https://www.governor.ny.gov/news/governor-hochul-announces-highlights-fy-2024-executive-budget>
10. Office of the Governor of New York. (2022). Governor Hochul Urges President Biden to Mobilize Federal Government for Shelter. Retrieved from <https://www.governor.ny.gov/news/governor-hochul-urges-president-biden-mobilize-federal-government-provide-shelter-asylum>
11. New York Times. (2023). Eric Adams' Right to Shelter Amid Migrant Crisis. Retrieved from <https://www.nytimes.com/2023/10/04/nyregion/eric-adams-right-to-shelter-migrant-crisis.html>
12. Associated Press. (2022). Mayor Eric Adams Plans to Bus Migrants, Challenges Gov. Greg Abbott. Retrieved from <https://apnews.com/article/mayor-eric-adams-bus-migrants-greg-abbott-cc9b1f7a7b1adf0fcd5c4e448a44dfac>
13. The Hill. (2022). 5 Things to Know About Border Bill HR2 and GOP Shutdown Threats. Retrieved from <https://thehill.com/homenews/house/4390204-5-things-to-know-about-border-bill-hr2-gop-shutdown-threats/>
14. American Medical Association. (2023). Immigration Status is a Public Health Issue (Resolution D-350.975). Retrieved from <https://policysearch.ama-assn.org/policyfinder/detail/%22Immigration%20Status%20is%20a%20Public%20Health%20Issue%20D-350.975%22?uri=%2FAMADoc%2Fdirectives.xml-D-350.975.xml>
15. American Medical Association. (2019). Addressing Immigrant Health Disparities (Resolution H-350.957). Retrieved from <https://policysearch.ama-assn.org/policyfinder/detail/asylum?uri=%2FAMADoc%2FHOD.xml-0-3007.xml>
16. World Health Organization. (2019). Seventy-Second World Health Assembly. Retrieved from https://iris.who.int/bitstream/handle/10665/331821/A72_REC1-en.pdf?sequence=1
17. International Organization for Migration. (2017). Colombo Statement on Migration Health. Retrieved from https://www.iom.int/sites/g/files/tmzbd1486/files/our_work/DMM/Migration-Health/colombo_statement.pdf

American Medical Association House of Delegates

Resolution: 017
(A-24)

Introduced by: New York

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, in the wake of the recent Harvard Anatomical Donation scandal, there is a clear need
2 to reform rules and regulations surrounding the use of anatomical specimens in medical
3 education, anthropological study, and related disciplines; and ^{1,2,3}
4

5 Whereas, America has a long and well-documented history of exploitation against American
6 Indians, Alaska Natives, people of color, immigrants, those with disabilities, incarcerated people,
7 non-Christian, and poor citizens, who historically have not been afforded the same rights as
8 white, able-bodied Americans; and ⁴⁻⁷
9

10 Whereas, preserved and skeletal anatomical specimens from as far back as the 1800s are still
11 held by medical schools and used for educational purposes today; and ⁸⁻¹²
12

13 Whereas, the need for anatomical specimens has long since outpaced supply now and even
14 more in the distant past; and ¹³
15

16 Whereas, in the 1800s the theft of the bodies of minority populations like that of indigenous,
17 enslaved, and free Black citizens was a common practice increasing supply of anatomical
18 specimens without attracting scrutiny from legal entities; and ¹⁴⁻¹⁶
19

20 Whereas, some institutions have begun decommissioning, cremating, or returning remains of
21 some slaves or minority populations; and ¹⁷⁻¹⁹
22

23 Whereas, other institutions have fought to hold on to remains like those of mother Bessie
24 Wilborn, who had Paget's disease, whose skeleton still hangs at the University of Georgia
25 against the wishes of her family; and ²⁰⁻²¹
26

27 Whereas, despite laws such as the Native American Graves and Repatriation Act, which
28 "requires federal agencies and institutions that receive federal funding to return Native American
29 "cultural items" to lineal descendants and culturally affiliated American Indian tribes, Alaska
30 Native villages, and Native Hawaiian organizations", museums and institutions of higher
31 learning have not complied with these laws; and ^{30, 31}
32

33 Whereas, Harvard holds human remains of 19 likely enslaved individuals and thousands of
34 Native Americans according to a recent report ²⁹⁻³⁰; and
35

36 Whereas, the Peabody Museum at Harvard stewards a collection of hair samples, and often
37 names, taken from Indigenous people including clippings of hair from approximately 700 Native
38 American children attending federal Indian Boarding Schools²⁹; and

1 Whereas, the final manifestation of medical racism is the use of patient's bodies without their
2 consent and the repatriation of these specimens is an important step toward healing minorities'
3 distrust in medicine²¹; and
4

5 Whereas, today many states have presumed consent laws that still allow for bodies that haven't
6 been claimed in as short as few days to be donated for dissection; and ^{27, 28}
7

8 Whereas, the majority of unclaimed bodies are non-white person, persons with mental health
9 issues, or are the bodies of low- income individuals; and ²⁶⁻²⁸
10

11 Whereas, the medical ethics community in America has expressed concern about presumed
12 consent in the case of organ donation due to potential for damage the relationship of trust
13 between clinicians caring for patients at the end of life and their families and loss of autonomy
14 especially amongst those least capable of registering objections; and ^{25, 26}
15

16 Whereas, AMA Code of Ethics 6.1.4. cautions against the practice of presumed consent for
17 deceased organ donation, but the AMA has no current policy on what constitutes ethical
18 consent processes for donation of cadavers or body parts following death for educational
19 purposes; and
20

21 Whereas, AMA Code of Ethics 6.1.3 provides guidelines on financial incentives for cadaveric
22 donations; however both opinions were developed in reports in 2002 and 2005 respectively, and
23 do not consider the issues from a lens of medical racism; and
24

25 Whereas, MSSNY recently passed comprehensive new policy at its 2024 HOD calling for
26 several actions to address the historical injustices of anatomical specimen use in NY State and
27 for forwarding proposed policy to the AMA; therefore be it
28

29 RESOLVED, that Our American Medical Association advocate to AAMC (Association of
30 American Medical Colleges) and other appropriate bodies for the return of human remains to
31 living family members, or, if none exist, the burial of anatomical specimens older than 2 years
32 where consent for permanent donation cannot be proven (Directive to Take Action); and be it
33 further
34

35 RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US
36 review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska
37 Native remains and immediately return remains and skeletal collections to tribal governments;
38 as required by laws such as the Native American Graves and Repatriation Act (Directive to
39 Take Action); and be it further
40

41 RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US
42 review their anatomical collections for remains of Black and Brown people and other minority
43 groups, and return remains and skeletal collections to living family members, or, if none exist,
44 then respectful burial of anatomical specimens or remains (Directive to Take Action); and be it
45 further
46

47 RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic
48 specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups
49 (Directive to Take Action); and be it further

1 RESOLVED, that Our AMA support the creation of a national anatomical specimen database
2 that includes registry demographics (New HOD Policy); and be it further

3
4 RESOLVED, that our AMA study and develop recommendations regarding regulations for
5 ethical body donations including, but not limited to guidelines for informed and presumed
6 consent; care and use of cadavers, body parts, and tissue (Directive to Take Action); and be it
7 further

8
9 RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for
10 Organs from Deceased Donors should be amended as follows:

- 11 ○ Physicians who propose to develop or participate in pilot studies of presumed
12 consent or mandated choice should ensure that the study adheres to the
13 following guidelines:
 - 14 ■ (a) Is scientifically well designed and defines clear, measurable outcomes
15 in a written protocol.
 - 16 ■ (b) Has been developed in consultation with the population among whom
17 it is to be carried out.
 - 18 ■ (c) Has been reviewed and approved by an appropriate oversight body
19 and is carried out in keeping with guidelines for ethical research.
- 20 ○ ~~Unless there are data that suggest a positive effect on donation, n~~ Neither
21 presumed consent nor mandated choice for cadaveric organ donation should be
22 widely implemented.

23 (Modify Current HOD Policy); and be it further

24
25 RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical
26 specimens, tissues and other human material that were collected and maintained for purposes
27 of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed
28 consent has been obtained are consistent with the goals of this resolution, and that
29 biospecimens donated for research, education, and transplantation with informed consents of
30 donors (or, if available, next of kin if deceased) are consistent with the goals of this resolution as
31 such materials can advance medical knowledge, improve the quality of healthcare and save
32 lives. (New HOD Policy)

Fiscal Note: To Be Determined

Received: 5/8/2024

REFERENCES:

1. McColgan, F. (2023, August 6). *New lawsuit against Harvard in wake of body part trafficking allegations puts victims first in complaint*. Spokesman.com. <https://www.spokesman.com/stories/2023/aug/06/new-lawsuit-against-harvard-in-wake-of-body-part-t/>
2. Li, D. K. (2023, June 14). *Harvard morgue theft ring stole body parts, sold brains and turned human flesh into leather*. NBC News. <https://www.nbcnews.com/news/us-news/4-charged-stealing-selling-human-body-parts-harvard-medical-school-mor-rcna89357>
3. Stelloh, T. (2023, June 22). *Harvard human remains case highlights need for body donation regulations, experts say*. NBC News. <https://www.nbcnews.com/news/us-news/harvard-human-remains-case-highlights-need-body-donation-regulations-e-rcna90524>
4. Hawkins, D. S. (2023, August 8). *Medical exploitation of Black people in America goes far beyond the cells stolen from Henrietta Lacks that produced modern day miracles*. The Conversation. <https://theconversation.com/medical-exploitation-of-black-people-in-america-goes-far-beyond-the-cells-stolen-from-henrietta-lacks-that-produced-modern-day-miracles-200220>
5. Christopher PP, Stein MD, Johnson JE, Rich JD, Friedmann PD, Clarke J, Lidz CW. Exploitation of Prisoners in Clinical Research: Perceptions of Study Participants. IRB. 2016 Jan-Feb;38(1):7-12. PMID: 26964404; PMCID: PMC4793400.

6. Sacks, T. K., Savin, K., & Walton, Q. L. (2021, February). *How ancestral trauma informs patients' health decision making*. Journal of Ethics | American Medical Association. <https://journalofethics.ama-assn.org/article/how-ancestral-trauma-informs-patients-health-decision-making/2021-02>
7. Ouellette, A. R. (2019). People with disabilities in human subjects research: A history of exploitation, a problem of exclusion. SSRN Electronic Journal. <https://doi.org/10.2139/ssrn.3492078>
8. Human dissection in the early years of medical education at UNC. (2016, April 27). UNC Libraries Blogs. <https://blogs.lib.unc.edu/uarms/2016/04/27/human-dissection-in-the-early-years-of-medical-education-at-unc/>
9. Research guides: Searching the Warren anatomical Museum collection: Home. (2023). Research Guides at Harvard Library. <https://guides.library.harvard.edu/c.php?g=311035>
10. History. (2023). University of Pennsylvania | Pathology and Laboratory Medicine. <https://pathology.med.upenn.edu/department/about-the-department/history>
11. Strydhorst, N. (2017, June 21). "New lives for old specimens" illuminates research with historical samples. Yale School of Medicine. <https://medicine.yale.edu/news-article/new-lives-for-old-specimens-illuminates-research-with-historical-samples/>
12. About. (2023). Mütter Museum Mütter Museum. <https://muttermuseum.org/about/overview>
13. Tward AD, Patterson HA. From Grave Robbing to Gifting: Cadaver Supply in the United States. JAMA. 2002;287(9):1183. doi:10.1001/jama.287.9.1183-JMS0306-6-1
14. Hawkins, D. S. (2023, August 8). *Medical exploitation of Black people in America goes far beyond the cells stolen from Henrietta Lacks that produced modern day miracles*. Stamford Advocate. <https://www.stamfordadvocate.com/news/article/medical-exploitation-of-black-people-in-america-18284630.php>
15. Hammond, K. (2023, February 8). *VCU's medical college history found to be 'intimately connected' with slavery, report finds*. WRIC ABC 8News. <https://www.wric.com/news/local-news/richmond/vcus-medical-college-history-found-to-be-intimately-connected-with-slavery-report-finds/>
16. Meier, A. (2019, February 18). *Grave robbing, Black cemeteries, and the American medical school*. JSTOR Daily. <https://daily.jstor.org/grave-robbing-black-cemeteries-and-the-american-medical-school/>
17. Reed, B. (2022, August 7). *Ivy League university set to rebury skulls of Black people kept for centuries*. The Guardian. <https://www.theguardian.com/us-news/2022/aug/07/us-university-plans-repatriation-black-american-remains>
18. Crimmins, P. (2021, April 27). *Penn Museum apologizes for 'Unethical possession of human remains'*. NPR. <https://www.npr.org/2021/04/27/988972736/penn-museum-apologizes-for-unethical-possession-of-human-remains>
19. Cheng, C. (2022, June 1). Harvard holds human remains of 19 likely enslaved individuals, thousands of Native Americans, draft report says. The Harvard Crimson. <https://www.thecrimson.com/article/2022/6/1/draft-human-remains-report/>
20. BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA. v. OGLESBY. No. A03A1375. (Court of Appeals of Georgia, November 21, 2003) <https://caselaw.findlaw.com/court/ga-court-of-appeals/1228176.html>
21. Washington, H. A. (2008). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Anchor.
22. Zink, S., Zeelandelaar, R., & Wertlieb, S. (2005, September). *Presumed vs expressed consent in the US and internationally*. Journal of Ethics | American Medical Association. <https://journalofethics.ama-assn.org/article/presumed-vs-expressed-consent-us-and-internationally/2005-09>
23. An evaluation of the ethics of presumed consent. A Report of the Presumed Consent Subcommittee of the Ethics Committee (June 1993). (1993, June). Organ Procurement and Transplantation Network. <https://optn.transplant.hrsa.gov/professionals/by-topic/ethical-considerations/an-evaluation-of-the-ethics-of-presumed-consent/>
24. Peeler, M. (2020). An unexpected education — Unclaimed bodies in the anatomy lab. *New England Journal of Medicine*, 383(21), 2002-2004. <https://doi.org/10.1056/nejmp2015975>
25. This is what happens to unclaimed bodies in America. (2022, December 19). *TalkDeath*. <https://www.talkdeath.com/this-is-what-happens-to-unclaimed-bodies-in-america/>
26. Jordan, M., & Sullivan, K. (2021, September 17). Alone in death-Tens of thousands die each year in the United States and no one claims their bodies. The Washington Post. <https://www.washingtonpost.com/nation/2021/09/17/alone-death/>
27. Sohn H, Timmermans S, Prickett PJ. Loneliness in life and in death? Social and demographic patterns of unclaimed deaths. *PLoS One*. 2020 Sep 16;15(9):e0238348. doi: 10.1371/journal.pone.0238348. PMID: 32936820; PMCID: PMC7494098.
28. Quinet, K., Nunn, S. and Ballew, A. (2016), Who are the Unclaimed Dead?. *J Forensic Sci*, 61: S131-S139. <https://doi.org/10.1111/1556-4029.12973>
29. Woodbury collection. (2023). Peabody Museum. <https://peabody.harvard.edu/woodbury-collection>
30. Jaffe, L., Hudetz, M., Ngu, A., & Brewer, G. L. (2023, January 11). America's biggest museums fail to return Native American human remains. ProPublica. <https://www.propublica.org/article/repatriation-nagpra-museums-human-remains>
31. Collins, B. (2018, September 18). *Mayo issues an apology 156 years in the making*. NewsCut. <https://newscut.mprnews.org/2018/09/mayo-issues-an-apology-156-years-in-the-making/index.html>

RELEVANT AMA POLICY

Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA:

- (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members
- (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Medical Ethics and Continuing Medical Education H-300.964

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making.

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors

Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

- (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
- (b) Has been developed in consultation with the population among whom it is to be carried out.
- (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.

Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-24)

Introduced by: New York

Subject: Opposing Violence, Terrorism, Discrimination, and Hate Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the American Medical Association represents hundreds of thousands of physicians
2 across the United States; and
3
4 Whereas, the AMA is committed to promoting the health and well-being of all individuals and
5 communities; and
6
7 Whereas, the AMA recognizes the inherent dignity and worth of every person, regardless of
8 race, ethnicity, gender, disability, religious affiliation, cultural affiliation, sexual orientation, or
9 other factor; and
10
11 Whereas, the AMA condemns all forms of violence, terrorism, discrimination, and hate speech
12 perpetrated against any group or individual; and
13
14 Whereas, the AMA acknowledges the ongoing conflicts and persecution faced by numerous
15 groups around the world, including but not limited to:
16
17 • Ethnic minorities such as the Rohingya in Myanmar, the Uighurs in China, and the Kurds
18
19 • Religious communities such as Jews, Muslims, Christians, Yazidis, etc.
20
21 • Indigenous populations
22
23 • LGBTQ+ individuals
24
25 • Refugees and asylum seekers in many countries
26
27 Whereas, current events including but not limited to the conflicts in the Middle East and Ukraine-
28 Russia provide context for this resolution and demonstrate the AMA's awareness of global
29 issues; and
30
31 Whereas, it is imperative for the AMA to address issues of recognition and commemoration in a
32 manner that fosters unity, understanding, and healing among all communities; therefore be it
33
34 RESOLVED, that our American Medical Association strongly condemns all acts of violence,
35 terrorism, discrimination, and hate speech against any group or individual, regardless of race,
36 ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other
37 factor (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms its commitment to promoting dialogue, empathy, and mutual
2 respect among diverse communities, recognizing the importance of fostering understanding and
3 reconciliation (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA recognizes the importance of commemorating and honoring the
6 victims of tragedies throughout human history, in a manner that respects the dignity and
7 sensitivities of all affected communities (New HOD Policy); and be it further
8

9 RESOLVED, that our AMA encourages initiatives that promote education, awareness, and
10 solidarity to prevent future acts of violence and promote social cohesion (New HOD Policy); and
11 be it further
12

13 RESOLVED, that our AMA acknowledges the diverse perspectives and experiences within its
14 membership and commits to facilitating constructive dialogue and engagement on sensitive and
15 polarizing issues (New HOD Policy); and be it further
16

17 RESOLVED, that our AMA calls for continued collaboration and partnership with organizations
18 representing diverse communities. (Directive to Take Action)
19

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

Received: 5/8/2024

AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution 019
(A-24)

Introduced by: Minority Affairs Section

Subject: Supporting the Health of Our Democracy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association “acknowledges voting is a social determinant of
2 health and significantly contributes to the analyses of other social determinants of health as a
3 key metric”; and
4
5 Whereas, our AMA “recognizes that gerrymandering which disenfranchises
6 individuals/communities limits access to health care, including but not limited to the expansion
7 of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and
8
9 Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to
10 firmly establish a relationship between voter participation and health outcomes”; and
11
12 Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and
13 teaching hospitals facilitating nonpartisan voter registration efforts¹; and
14
15 Whereas, a growing body of research demonstrates the relationship between the political
16 determinants of health (including voter rates, government participation, and policy engagement)
17 and other social determinants, including how votes lost to morbidity and mortality in
18 underrepresented populations impact electoral and policy outcomes²⁻⁴; and
19
20 Whereas, lower voter rates among elderly patients, patients with disabilities, patients who are
21 socially isolated, and low-income patients are associated with poor reported health, and
22 increased voter rates are associated with healthier lifestyle behaviors and improved mental
23 health, even when controlling for income inequality⁴⁻¹⁰; and
24
25 Whereas, health facilities’ nonpartisan voter registration efforts demonstrate improved civic
26 engagement and are protected by the National Voter Registration Act and IRS code¹¹⁻¹⁴; and
27
28 Whereas, emergency absentee ballot access for people experiencing or managing medical
29 emergencies is variable across states, with only 23 offering coverage for patients’ relatives and
30 only 17 extending protections to healthcare workers¹²; and
31
32 Whereas, physician voter rates are lower than the general public, often due to work conflicts,
33 although rates are higher in states with universal mail ballots¹⁵⁻¹⁶; and
34
35 Whereas, President Biden’s Executive Order on Promoting Access to Voting strongly
36 encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health
37 Service sites to seek designation as voter registration sites¹⁷; and

1 Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC
 2 offer voter registration services, and the Health Resources and Services Administration even
 3 offers guidance for Federally Qualified Health Centers to organize such efforts^{12,18-19}; and
 4

5 Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian
 6 Health Programs, which are crucial interfaces with Native American patients and Tribal
 7 governments²⁰⁻²¹; and
 8

9 Whereas, gerrymandering disenfranchises voters, especially voters of color and low-income
 10 voters, resulting in electoral outcomes that do not accurately reflect popular votes and
 11 subsequent governments who often limit ballot access once in power²²⁻²⁴; and
 12

13 Whereas, increased gerrymandering and barriers to ballot access are associated with lower life
 14 expectancies, obstruction of Medicaid expansion, and perpetuation of systemic racial health
 15 inequities, especially among Black, Latine, and Native American populations^{3,23-24}; and
 16

17 Whereas, the primary solution to gerrymandering is the creation of independent, nonpartisan
 18 redistricting commissions, so if our AMA recognizes that gerrymandering is a threat to health
 19 outcomes, then we should support solutions to mitigate this problem²⁵; therefore be it
 20

21 RESOLVED, that our American Medical Association support policies that ensure safe and
 22 equitable access to voting and opposes the institutional barriers to both the process of voter
 23 registration and the act of casting a vote (New HOD Policy); and be it further
 24

25 RESOLVED, that our AMA encourage physicians and medical trainees to vote, oppose barriers
 26 to their participation in the electoral process, and support their and other healthcare workers'
 27 engagement in nonpartisan voter registration efforts in healthcare settings, including emergency
 28 absentee ballot procedures for qualifying patients, visitors, and healthcare workers (New HOD
 29 Policy); and be it further
 30

31 RESOLVED, that our AMA support the use of independent, nonpartisan commissions to draw
 32 districts for both federal and state elections. (New HOD Policy)

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

Date Received: 5/8/2024

REFERENCES

1. Fact Sheet for Nonpartisan Voter Registration at Health Care Institutions. AAMC. Accessed May 14, 2023. <https://www.aamc.org/advocacy-policy/voterregistration>
2. Social Determinants of Health. Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/priority-areas/social-determinants-health>. Accessed June 6, 2023.
3. Syed Q, Schmidt S, Powell R, Henry T, Connolly N, Cowart J, Newby C. Gerrymandering and Political Determinants of Health. Mary Ann Liebert, Inc. Published Aug 8, 2022. <https://doi.org/10.1089/pop.2021.0362>
4. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. Public Health Rev. 2020;41:16.
5. Nelson MH. Explaining socioeconomic disparities in electoral participation: The role of health in the SES-voting relationship. Soc Sci Med. 2023;320:115718. doi:10.1016/j.socscimed.2023.115718
6. Ballard PJ, Hoyt LT, Pachucki MC. Impacts of adolescent and young adult civic engagement on health and socioeconomic status in adulthood. Child Dev 2018;00(0):1-17. Available from:<http://doi.wiley.com/10.1111/cdev.12998>.
7. Arah OA. Effect of voting abstention and life course socioeconomic position on self-reported health. J Epidemiol Community Health. 2008;62(8):759-60. <https://doi.org/10.1136/jech.2007.071100>.
8. Ballard PJ, Hoyt LT, Pachucki MC. Impacts of adolescent and young adult civic engagement on health and socioeconomic status in adulthood. Child Dev 2018;00(0):1-17. Available from:<http://doi.wiley.com/10.1111/cdev.12998>.

9. Bergstresser SM, Brown IS, Colesante A. Political engagement as an element of social recovery: a qualitative study. *Psychiatr Serv.* 2013;64(8):819-21 Available from:<http://psychiatryonline.org/doi/abs/10.1176/appi.ps.004142012>.
10. Kawachi I, Kennedy BP, Gupta V, Prothrow-Stith D. Women's status and the health of women and men: a view from the States. *Soc Sci Med.* 1999;48(1):21-32.
11. The National Voter Registration Act Of 1993 (NVRA). US Department of Justice. Published online July 20, 2022. <https://www.justice.gov/crt/national-voter-registration-act-1993-nvra>
12. Tang OY, Wong KE, Ganguli R, et al. Emergency Absentee Voting for Hospitalized Patients and Voting During COVID-19: A 50-State Study. *West J Emerg Med.* 2021;22(4):1000-1009. Published 2021 Jul 15. doi:10.5811/westjem.2021.4.50884
13. Lickiss S, Lowery L, Triemstra JD. Voter Registration and Engagement in an Adolescent and Young Adult Primary Care Clinic. *J Adolesc Health.* 2020;66(6):747-749. doi:10.1016/j.jadohealth.2019.11.316
14. Chamberlain C, Jaime H, Wohler D. Emergency Patient Voting Initiative in a Community Hospital During a Global Pandemic:: Lessons and a Call-to-Action for Expanded Voter Access. *Delaware J Public Health.* 2021;7(1):76-77. Published 2021 Jan 21. doi:10.32481/djph.2021.01.015
15. Solnick RE, Choi H, Kocher KE. Voting Behavior of Physicians and Healthcare Professionals. *J Gen Intern Med.* 2021;36(4):1169-1171. doi:10.1007/s11606-020-06461-2
16. Ahmed A, Chouairi F, Li X. Analysis of Reported Voting Behaviors of US Physicians, 2000-2020. *JAMA Netw Open.* 2022;5(1):e2142527. doi:10.1001/jamanetworkopen.2021.42527
17. Biden J. Executive Order on Promoting Access to Voting. The White House. Published online March 7, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/03/07/executive-order-on-promoting-access-to-voting>
18. VA promotes greater access to voter information to Veterans and families. Veterans Affairs. Published online March 24, 2022. <https://news.va.gov/press-room/va-promotes-greater-access-to-voter-information-to-veterans-and-families>
19. Hess D. Using Medicaid Automatic Voter Registration to Address Persistent Voter Registration Problems: Helping the National Voter Registration Act Achieve its Potential. Institute for Responsive Government. Published online June 23, 2023. <https://responsivegoverning.org/research/using-medicaid-automatic-voter-registration-to-address-persistent-voter-registration-problems-helping-the-national-voter-registration-act-achieve-its-potential>
20. Title I | Office of Direct Service and Contracting Tribes. Title I | Office of Direct Service and Contracting Tribes. Office of Direct Service and Contracting Tribes. Current as of 2023. <https://www.ihs.gov/odsct/title1/>
21. Martin A, Raja A, Meese H. Health care-based voter registration: a new kind of healing. *International Journal of Emergency Medicine.* Published online April 30, 2021. doi:<https://doi.org/10.1186/s12245-021-00351-y>
22. Cavell S. Why Gerrymandering Matters. Harvard University Press. July 9, 2018. Accessed May 28, 2023. https://harvardpress.typepad.com/hup_publicity/2018/07/why-gerrymandering-matters-allan-lichtman.html
23. Tausanovitch A and Root D. How Partisan Gerrymandering Limits Voting Rights. The Center for American Progress. July 8, 2020. Accessed May 28, 2023. <https://www.americanprogress.org/article/partisan-gerrymandering-limits-voting-rights/>
24. Study Finds Residents with Reduced Voter Access and in Gerrymandered States Have Worse Health Outcomes. Union of Concerned Scientists. Nov 7, 2019. Accessed on May 28, 2023. <https://www.ucsusa.org/about/news/study-finds-residents-reduced-voter-access-and-gerrymandered-states-have-worse-health>
25. Independent Redistricting Commissions. Campaign Law Center. Accessed on Sep 18, 2023. <https://campaignlegal.org/democracyu/accountability/independent-redistricting-commissions>

RELEVANT AMA POLICY

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections D-65.982

Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows, and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community; and (2) work with appropriate stakeholders to ensure that medical students, residents, fellows and physicians are allowed time to vote without penalty on Election Days.

AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution: 020
(A-24)

Introduced by: Minority Affairs Section

Subject: Voter Protections During and After Incarceration

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association “acknowledges voting is a social determinant of
2 health and significantly contributes to the analyses of other social determinants of health as a
3 key metric”; and
4
5 Whereas, our AMA “recognizes that gerrymandering which disenfranchises
6 individuals/communities limits access to health care, including but not limited to the expansion
7 of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and
8
9 Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to
10 firmly establish a relationship between voter participation and health outcomes”; and
11
12 Whereas, states that increase access to voting experience stronger public health outcomes and
13 better self-reported health status of individuals, while reduced access to voting has been linked
14 to poorer health outcomes and decreased health coverage¹⁻⁴; and
15
16 Whereas, barriers to voting in the United States have been associated with an increased
17 likelihood of not having access to health care coverage, thereby making the government less
18 accountable to the needs of its people⁵; and
19
20 Whereas, past expansion of suffrage resulted in improved maternal outcomes following
21 women’s suffrage in 1920 and reduced Black infant mortality correlated with the Voting Rights
22 Act of 1965, due to policies passed by legislators after the addition of these voters⁶; and
23
24 Whereas, 48 states currently restrict the right to vote of 4.6 million citizens convicted beyond a
25 misdemeanor, and many states permanently bar them from voting⁷⁻⁹; and
26
27 Whereas, the Fifth Circuit Court of Appeals ruled in August 2023 that a state violated the US
28 Constitution by inflicting cruel and unusual punishment by stripping the right to vote from
29 citizens who were convicted¹⁰; and
30
31 Whereas, since 2020, 7 states passed laws allowing citizens to vote while on parole⁷; and
32
33 Whereas, Black and Latine people are imprisoned 5 times and 1.3 times as much as white
34 people, respectively¹¹; and
35
36 Whereas, racial inequities in incarceration extend to voter rights for citizens who are
37 incarcerated as well, with 5.3% of Black incarcerated citizens banned compared to 1.5% of non-
38 Black incarcerated citizens⁹; and

1 Whereas, Black men comprise over one-third of the total disenfranchised population, are
 2 disproportionately impacted by policing and overrepresented in the carceral system, and could
 3 comprise as much as 40% in states that restrict incarcerated citizens' right to vote,
 4 demonstrating that restriction of voter rights in incarceration substantially contributes to the
 5 disenfranchisement of Black citizens¹²; therefore be it
 6

7 RESOLVED, that our American Medical Association support the continuation and restoration of
 8 voting rights for citizens currently or formerly incarcerated, support efforts ensuring their ability
 9 to exercise their vote during and after incarceration, and oppose efforts to restrict their voting
 10 rights (New HOD Policy); and be it further

11
 12 RESOLVED, that our AMA research the impact of disproportionate policing in and incarceration
 13 of minoritized communities on voter participation and health outcomes (Directive to Take
 14 Action); and be it further

15
 16 RESOLVED, that our AMA develop educational materials and programming to educate medical
 17 trainees and physicians on the impact of incarceration on voting and health outcomes. (Directive
 18 to Take Action)

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

Date Received: 5/8/2024

REFERENCES

1. Schraufnagel S, Pomante li MJ, Li Q. Cost of Voting in the American States: 2020. *Election Law J Rules Polit Policy*. 2020;19(4):503-509. doi:10.1089/elj.2020.0666
2. Ganguly A, Morelli D, Bhavan KP. Voting As a Social Determinant of Health: Leveraging Health Systems to Increase Access to Voting. *Catal Non-Issue Content*. 2023;4(1). doi:10.1056/CAT.22.0368
3. Kim S, Kim C yup, You MS. Civic Participation and Self-rated Health: A Cross-national Multi-level Analysis Using the World Value Survey. *J Prev Med Pub Health*. 2015;48(1):18-27. doi:10.3961/jpmph.14.031
4. Pabayo R, Liu SY, Grinshteyn E, Cook DM, Muennig P. Barriers to Voting and Access to Health Insurance Among US Adults: A Cross-Sectional Study. *Lancet Reg Health - Am*. 2021;2:100026. doi:10.1016/j.lana.2021.100026
5. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. *Public Health Rev*. 2020;41:16. doi:10.1186/s40985-020-00133-6
6. Ehlinger EP, Nevarez CR. Safe and Accessible Voting: The Role of Public Health. *Am J Public Health*. 2021;111(1):45-46. doi:10.2105/AJPH.2020.306011
7. Felon Voting Rights. Accessed August 27, 2023. <https://www.ncsl.org/elections-and-campaigns/felon-voting-rights>
8. Felony Disenfranchisement Laws (Map). American Civil Liberties Union. Accessed August 27, 2023. <https://www.aclu.org/issues/voting-rights/felony-disenfranchisement-laws-map>
9. Stewart CU Ryan Larson, Sarah Shannon and Robert. Locked Out 2022: Estimates of People Denied Voting Rights. The Sentencing Project. Published October 26, 2022. Accessed August 27, 2023. <https://www.sentencingproject.org/reports/locked-out-2022-estimates-of-people-denied-voting-rights>
10. Press TA. An appeals court blocks Mississippi's permanent ban on voting after certain felonies. *NPR*. <https://www.npr.org/2023/08/04/1192295228/mississippi-felon-voting-law-blocked>. Published August 4, 2023. Accessed August 27, 2023.
11. Nellis A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. The Sentencing Project. Published October 13, 2021. Accessed August 27, 2023. <https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project>
12. Overview and Summary Losing the Vote: The Impact of Felony Disenfranchisement Laws in the United States. Accessed August 27, 2023. <https://www.hrw.org/legacy/reports98/vote/usvot98o.htm>
13. Homan PA, Brown TH. Sick And Tired Of Being Excluded: Structural Racism In Disenfranchisement As A Threat To Population Health Equity. *Health Affairs*. 2022;41(2):219-227. doi:10.1377/hlthaff.2021.01414

RELEVANT AMA POLICY

Mental Illness and the Right to Vote H-65.971

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Support for Democracy H-65.947

Our AMA: (1) unequivocally supports the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans; (2) will strongly oppose attempts to subvert the democratic process; and (3) asserts that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-24)

Introduced by: Minority Affairs Section

Subject: Opposition to Capital Punishment

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the principle of medicine “to help and do no harm” is related to beneficence, which
2 speaks to the obligation of the physician to act for the benefit of the patient and remove
3 conditions that will cause harm, and nonmaleficence, which is concerned with weighing the
4 benefits and burdens of medical interventions and proceeding with the best choice for the
5 patient that minimizes harm and suffering;¹ and
6

7 Whereas, capital punishment, or the death penalty, is defined by the United States Bureau of
8 Justice Statistics as “the process of sentencing convicted offenders to death for the most
9 serious crimes (capital crimes) and carrying out that sentence” where the specific offenses are
10 “defined by statute and are prescribed by Congress or any state legislature”;² and
11

12 Whereas, forms of capital punishment used in the United States include electrocution, lethal
13 injection, and firing squad;^{3,4} and
14

15 Whereas, 24 individuals in 5 states (Texas, Oklahoma, Missouri, Alabama, and Florida) executed
16 in 2023;^{2,5} and
17

18 Whereas, supporters of capital punishment argue that the practice saves on costs of
19 incarceration, but these arguments have also proven to be categorically false, as many states
20 actively spend millions of additional dollars annually to uphold these policies;⁶⁻¹⁰ and
21

22 Whereas, 23 states have abolished capital punishment without significant changes in crime or
23 murder rates, challenging the argument that it effectively deters serious crimes;¹¹⁻¹⁷ and
24

25 Whereas, in response to drug shortages, manufacturing changes, high cost, and manufacturer
26 reluctance to sell drugs for execution, prisons are introducing novel forms of capital punishment
27 including nitrogen hypoxia and midazolam (in lieu of phenobarbital), in addition to attempts to
28 procure drugs for lethal injection from illegal and untraceable sources;¹⁸⁻²⁰ and
29

30 Whereas, current methods of capital punishment used in the United States have been
31 associated with severe, distressful symptoms, in addition to the inherent harm caused by the act
32 of capital punishment itself;²¹⁻²³ and
33

34 Whereas, nitrogen hypoxia is opposed as a use of euthanasia by the American Veterinary
35 Medical Association due to its ability to cause distress in nonhuman animals;²⁴ and
36

37 Whereas, the threshold for an acceptable amount of suffering in humans is widely considered to
38 be lower than for suffering in nonhuman animals;²⁵ and
39

40 Whereas, the AMA’s amicus brief in the 2018 Supreme Court case *Bucklew v. Precythe* relating

1 to novel forms of capital punishment states “Society wants to delude itself into a belief that
2 capital punishment no longer represents a weighted moral choice, but is now somehow
3 scientific—nearly antiseptic. This delusion, however, cheapens life and makes its extinction
4 easier. The medical profession, whose ‘essential quality’ is an interest in humanity and which
5 reveres human life should have no part in this charade.”;²⁶ and
6

7 Whereas, AMA Code of Medical Ethics Opinion 9.7.3 Capital Punishment states clearly that “as
8 a member of a profession dedicated to preserving life when there is hope of doing so, a
9 physician must not participate in a legally authorized execution”; and
10

11 Whereas, AMA Code 9.7.3 only addresses physician participation in executions and does not
12 address the AMA’s advocacy stance on capital punishment, so an attempt to change the AMA’s
13 advocacy stance on this issue does not require an amendment to the Code; therefore be it
14

15 RESOLVED, that our American Medical Association amend H-140.896, “Moratorium on Capital
16 Punishment,” by addition and deletion as follows:
17

18 **Opposition to Moratorium on Capital Punishment H-140.896**

19 Our AMA: (1) opposes all forms of ~~does not take a position~~ on
20 capital punishment; and (2) urges appropriate legislative and legal
21 authorities to continue to implement changes in the system of
22 administration of capital punishment, if used at all, and to promote
23 its fair and impartial administration in accordance with basic
24 requirements of due process.

25 (Modify Current HOD Policy)

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

Received: 5/8/2024

REFERENCES

1. Varkey B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30(1):17-28. doi:10.1159/000509119
2. Bureau of Justice Statistics. Capital Punishment. Bureau of Justice Statistics. Published February 18, 2021. <https://bjs.ojp.gov/topics/corrections/capital-punishment>
3. Tarm M. Why executions by firing squad may be coming back in the US. AP News. Published March 24, 2023. <https://apnews.com/article/death-penalty-executions-firing-squads-idaho-74803c0de8a50a512bdb52dae4974570>
4. Death Penalty Information Center. Methods of Execution. Death Penalty Information Center. Published 2023. <https://deathpenaltyinfo.org/executions/methods-of-execution>
5. Cason M. Only 4 states besides Alabama have carried out executions in 2023. Al.com. Published December 1, 2023. Accessed March 4, 2024. <https://www.al.com/news/2023/12/only-4-states-besides-alabama-have-carried-out-executions-in-2023.html>
6. Death Penalty Cost. Amnesty International USA. Published June 26, 2023. Accessed March 1, 2024. [https://www.amnestyusa.org/issues/death-penalty/death-penalty-facts/death-penalty-cost/#:~:text=\(%24232.7%20million%20per%20year](https://www.amnestyusa.org/issues/death-penalty/death-penalty-facts/death-penalty-cost/#:~:text=(%24232.7%20million%20per%20year)
7. Death Penalty Information Center. Costs. Death Penalty Information Center. Published 2023. <https://deathpenaltyinfo.org/policy-issues/costs>
8. Death Penalty Information Center. Costs: Louisiana Spent \$7.7 Million on Death Penalty Defense in One Year. It Hasn't Executed Anyone in 13 Years. Death Penalty Information Center. Published March 27, 2023. <https://deathpenaltyinfo.org/news/costs-louisiana-spent-7-7-million-on-death-penalty-defense-in-one-year-it-hasnt-executed-anyone-in-13-years>
9. Death Penalty Information Center. State Studies on Monetary Costs. Death Penalty Information Center. Published 2022. <https://deathpenaltyinfo.org/policy-issues/costs/summary-of-states-death-penalty>
10. Yost D. 2022 Ohio Capital Crimes Annual Report. Ohio Attorney General's Office; 2023. Accessed March 1, 2024. <https://www.ohioattorneygeneral.gov/Files/Reports/Capital-Crimes-Annual-Reports/2022CapitalCrimesAnnualReport>
11. Oliphant SN. Estimating the effect of death penalty moratoriums on homicide rates using the synthetic control method. Criminology & Public Policy. 2022;21(4). doi:https://doi.org/10.1111/1745-9133.12601
12. Death Penalty Information Center. Murder Rate of Death Penalty States Compared to Non-Death Penalty States. Death Penalty Information Center. Published 2020. <https://deathpenaltyinfo.org/facts-and-research/murder-rates/murder-rate-of-death-penalty-states-compared-to-non-death-penalty-states>

13. Nagin DS. Deterrence in the Twenty-First Century. *Crime and Justice*. 2013;42(1):199-263. doi:<https://doi.org/10.1086/670398>
14. National Institute of Justice. Five Things about Deterrence; 2016:1-2. <https://www.ojp.gov/pdffiles1/nij/247350.pdf>
15. Parker B. Death Penalty Statutes and Murder Rates: Evidence From Synthetic Controls. *Journal of Empirical Legal Studies*. 2021;18(3):488-533. doi:<https://doi.org/10.1111/jels.12291>
16. Heflin J. The Impact of Execution Moratoriums on Homicide Rates. *Social Science Research Network*. 2023;(4525716).doi:<https://doi.org/10.2139/ssrn.4525716>
17. Amnesty International. Does the Death Penalty Deter Crime? Amnesty International; 2021. <https://www.amnesty.org/en/wp-content/uploads/2021/06/act500062008en.pdf>
18. Death Penalty Information Center. Arizona DoC Paid \$1.5 Million for Execution Drugs While Facing a Budget Crisis. Death Penalty Information Center. Published April 15, 2021. <https://deathpenaltyinfo.org/news/arizona-doc-paid-1-5-million-for-execution-drugs-while-facing-a-budget-shortfall>
19. Death Penalty Information Center. Overview of Lethal Injection Protocols. Death Penalty Information Center. Published 2024. <https://deathpenaltyinfo.org/executions/lethal-injection/overview-of-lethal-injection-protocols>
20. Fixler K. Idaho found lethal injection drugs for an execution. Here's how much they cost taxpayers. *Idaho Statesman*. <https://www.idahostatesman.com/news/northwest/idaho/article281926143.html>. Published December 15, 2023. Accessed March 1, 2024.
21. Caldwell N, Chang A, Myers J. Gasping For Air: Autopsies Reveal Troubling Effects Of Lethal Injection. NPR. Published September 21, 2020. <https://www.npr.org/2020/09/21/793177589/gasping-for-air-autopsies-reveal-troubling-effects-of-lethal-injection>
22. Thomson-DeVeaux A. Is The Firing Squad More Humane Than Lethal Injection? *FiveThirtyEight*. Published March 2, 2017. <https://fivethirtyeight.com/features/is-the-firing-squad-more-humane-than-lethal-injection/#:~:text=A%20study%20conducted%20in%201993>
23. Death Penalty Information Center. Description of Each Execution Method. Death Penalty Information Center. Published 2024. <https://deathpenaltyinfo.org/executions/methods-of-execution/description-of-each-method>
24. Leary S, Johnson C. AVMA Guidelines for the Euthanasia of Animals: 2020 Edition; Members of the Panel on Euthanasia AVMA Staff Consultants; 2020. <https://www.avma.org/sites/default/files/2020-02/Guidelines-on-Euthanasia-2020.pdf>
25. Wendler D. Degrees of Moral Status: The Problem of Relevance and the Need for a Threshold. *Erkenntnis*. Published online November 14, 2023. doi:<https://doi.org/10.1007/s10670-023-00737-9>
26. *Bucklew v. Precythe* (S.Ct.). American Medical Association. Published 2018. Accessed March 25, 2024. https://searchlhf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fcase%2FCase-Summary_Bucklew-v-Precythe.pdf

RELEVANT AMA Policy

H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. [Sub. Res. 8, A-01; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17]

Code of Medical Ethics 9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner. These include, but are not limited to:
 - (d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
 - (e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.
 - (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that

are part of the execution procedure.

- (g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
- (h) Attending or observing an execution as a physician.
- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (j) Selecting injection sites.
- (k) Starting intravenous lines as a port for a lethal injection device.
- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
- (m) Inspecting, testing, or maintaining lethal injection devices.
- (n) Consulting with or supervising lethal injection personnel. 20

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if:

- (u) The decision to donate was made before the prisoner's conviction.
- (v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
- (w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. [AMA Principles of Medical Ethics: I; Issued: 2016]

H-140.950 Physician Participation in Capital Punishment

Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following: (1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed. (2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins. (3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements. Treatment should be provided in a properly-secured, general medical or psychiatric facility, not

in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician. [CEJA Rep. 6, A-95; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14; Reaffirmed in lieu of Res. 7, A-14]

H-140.898 Medical Profession Opposition to Physician Participation in Execution

Our AMA strongly reaffirms its opposition to physician participation in execution. [Res. 10, A-02; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols

Our AMA will remind all state medical societies to review their state execution statutes to ensure that physician participation is not required. [Res. 3, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20]

H-140.963 Secrecy and Physician Participation in State Executions

The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution. [Res. 6, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(A-24)

Introduced by: Minority Affairs Section

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and
3 social determinants of health — to eliminate disparities in health and health care¹; and
4
- 5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is
6 essential to optimizing health care access and the quality of patient care; and
7
- 8 Whereas, many barriers remain and unique challenges persist for some diverse groups
9 attempting to enter the medical field and successfully matriculate through the profession of
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and
11
- 12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%
13 identified as Hispanic, and ~5.0% identified as Black or African American²; and
14
- 15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to
18 increase by 26% by 2030;^{3,4} and
19
- 20 Whereas, black people account for roughly 13 percent of the US population, they make up only
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These
23 representational disparities have not changed appreciably in decades;^{3,4} and
24
- 25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates
26 of remedial intervention and dismissal from their programs than their White counterparts, thus
27 leading to concerns of over-policing in medical education; and
28
- 29 Whereas, over-policing in education begins as early as primary school and continues through
30 high school, college, medical education, and into the workforce. In graduate medical
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in
32 the residency selection process;⁵ and
33
- 34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly
35 20% of those who were dismissed in 2015;⁷and
36
- 37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms
38 of depression and anxiety among minority students, residents and physicians. This often leads

1 to reducing practice hours or leaving medicine, creating even greater workforce
2 disparities;⁵ therefore be it

3
4 RESOLVED, that our American Medical Association further study and track the prevalence of
5 attending physicians' and trainees' dismissals and remedial interventions, based on race,
6 gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities
7 (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA engage stakeholders to study and report back how to effectively
10 support underrepresented groups in medicine to level the playing field for those most affected
11 by bias and historical harms (Directive to Take Action); and be it further

12
13 RESOLVED, that our AMA work with stakeholders to make recommendations on a review and
14 appeals process that will enable physicians and trainees to receive a fair and equitable due
15 process in defense of alleged shortcomings. (Directive to Take Action)

16
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/8/2024

REFERENCES

1. U.S. Department of Health and Human Services. (n.d.). Achieving health equity. Healthy People 2030. Retrieved from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030#:~:text=Achieving%20health%20equity%20requires%20valuing,in%20health%20and%20health%20care>
2. Association of American Medical Colleges. (2018). Percentage of All Active Physicians by Race/Ethnicity: 2018. Retrieved from <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018#:~:text=Among%20active%20physicians%2C%2056.2%25%20identified,subgroup%20after%20White%20and%20Asian>
3. Johnson, T. (2023, March 23). Analysis: Racism in academic medicine is hindering progress toward health equity. California Health Report. Retrieved from <https://www.calhealthreport.org/2023/03/23/analysis-racism-in-academic-medicine-is-hindering-progress-toward-health-equity/>
4. University of California, Los Angeles. (n.d.). Proportion of Black Physicians Shows Little Change. Retrieved from <https://newsroom.ucla.edu/releases/proportion-black-physicians-little-change>
5. Health Care News. (n.d.). Dismantling the overpolicing of Black residents. Retrieved from <https://hcn.health/hcn-trends-story/dismantling-the-overpolicing-of-black-residents/>
6. Commonwealth Fund. (2024, February). Revealing disparities: Health care workers' observations. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/revealing-disparities-health-care-workers-observations>
7. Ryan, P. (2022, June 20). Black doctors forced out of training programs at far higher rates than white residents. STAT. Retrieved from <https://www.statnews.com/2022/06/20/black-doctors-forced-out-of-training-programs-at-far-higher-rates-than-white-residents/>
8. Ryan, P. (2022, June 21). What will it take to level the playing field for Black residents? STAT. Retrieved from <https://www.statnews.com/2022/06/21/what-will-it-take-to-level-the-playing-field-for-black-residents/>
9. Jha, A. K. (2022). Structural racism and inequity in medicine. *New England Journal of Medicine*, 386(14), 1353-1356. doi: 10.1056/NEJMp2304559
10. Wadhwa, R. K., & Yeh, R. W. (2022). Addressing racism in medicine — toward a more equitable future. *New England Journal of Medicine*, 386(18), 1743-1746. doi: 10.1056/NEJMp2306195

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support

individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16 Modified: Res. 009, A-21 Modified: CME Rep. 5, A-21]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03 Appended: CME Rep. 6, A-11 Modified: CME Rep. 3, A-13 Appended: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Appended: Res. 319, A-22 Modified: Res. 319, A-23]

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. [CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-21]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs. [CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19 Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23]