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REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-24

Subject: Increasing Access to Medical Care for People Seeking Asylum
(Resolution 007-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 INTRODUCTION

2
3 At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates
4 (HOD), the Medical Student Section submitted Resolution 007 “Improving Access to Forensic
5 Medical Evaluations and Legal Representation for Asylum Seekers” that asked the AMA to:

6
7 Support public funding of legal representation for people seeking legal asylum (New HOD
8 Policy); and be it further

9
10 Support efforts to train and recruit physicians to conduct medical and psychiatric forensic
11 evaluations for all asylum seekers through existing training resources, including, but not
12 limited to, the Asylum Medicine Training Initiative.

13
14 Testimony was mixed. Concerns were raised about the first resolve clause, noting it may be outside
15 the purview of the AMA. Also, testimony suggested deletion of “Asylum Medicine Training
16 Initiative” from the second resolve to avoid endorsement of a specific program. The resolution was
17 referred.

18 19 BACKGROUND

20
21 2022 data from the World Health Organization states that more than 1 billion people globally — or
22 one in seven people — are refugees, immigrants, and migrants (RIM).¹ Such RIM communities
23 often experience economic, educational, social, and health inequities.² Many have also been
24 victims of great harms.

25 26 *Definition of asylum seeker*

27
28 To better understand the issues raised in this resolution, we must first be clear on the definitions of
29 key terms. The U.S. Citizen and Immigration Services (USCIS) of the U.S. Department of
30 Homeland Security (DHS) and the International Rescue Committee (IRC) provide such definitions.
31 Key terms are defined and compared in Appendix A. This report will focus on the term “asylum
32 seeker” since it is the one written in the resolution. An “asylum seeker” (or asylee) is a person who
33 is “an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her
34 country of nationality, or to seek the protection of that country because of persecution or a well-
35 founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality,

1 membership in a particular social group or political opinion.”¹ They must arrive at or cross a border
2 into the desired country and apply for protection. An asylum seeker’s claim for refugee status has
3 not yet been legally determined.³

4
5 According to the ICR, there were 6.9 million asylum seekers in 2023. The United States received
6 the largest number of applications, followed by Germany. The most applications came from
7 individuals departing Afghanistan, Colombia, Sudan, Syria, and Venezuela.³ Many of these
8 individuals, particularly women and children, report having fled their native country due to such
9 atrocities as kidnappings, gender violence, forced gang recruitment, and even murder. Crossing an
10 international border for asylum is legal, and the individual’s case must be heard, per U.S. and
11 international law.³

12 13 *Applying for asylum*

14
15 Asylum seekers must apply to the USCIS. To qualify, one must be physically present in the U.S. If
16 one is eligible for asylum, then they may be permitted to remain in the U.S. Such persons must file
17 a [Form I-589](#) “Application for Asylum and for Withholding of Removal” within one year of
18 arrival.⁴ The DHS website provides further information on the ways to obtain asylum. The
19 information is available in English and Spanish; they also offer a [Multilingual Resource Center](#) to
20 assist those who read/speak other languages.

21 22 *Legal representation*

23
24 The U.S. Department of Justice provides [lists](#) of pro bono (free) legal service providers per state to
25 help asylum seekers navigate the process. States themselves also provide resources to asylum
26 seekers who have recently arrived. One such example is the Illinois Department of Human
27 Services, which offers a [list](#) of community service agencies that provide a variety of services
28 including legal aid.⁵ Some cities have even established funding mechanisms to support such
29 individuals. The city of Chicago invests in its Legal Protection Fund in partnership with the
30 National Immigrant Justice Center (NIJC) and The Resurrection Project “to provide community-
31 based outreach, education, legal consultations and courtroom representation for thousands of
32 immigrants each year.”⁶ Various organizations work to ensure access to justice and human rights
33 protections for asylum seekers (as well as immigrants and refugees). As mentioned, the NIJC
34 advocates for policy reform and systems change while also offering legal services for said
35 individuals. Such direct services generally involve volunteer attorneys providing pro bono services.
36 The NIJC serves more than 10,000 asylum seekers each year with a 90 percent success rate in
37 obtaining asylum.⁷

38 39 *Medical evaluation*

40
41 The Centers for Disease Control and Prevention (CDC), United States Public Health Service , is
42 responsible for ensuring that noncitizens entering the U.S. do not pose a risk to the health of U.S.
43 citizens and U.S. legal residents. Thus, each person is required to receive a medical (physical and
44 mental) examination when applying for entry. Detailed information about the medical examination
45 performed by designated physicians can be found on the CDC [website](#). The Department of Health
46 and Human Services (HHS) Office of Refugee Settlement also promotes the health, well-being, and
47 stability of refugees, unaccompanied children, and other eligible individuals and families. For
48 children, this office operates the Unaccompanied Refugee Minors Program and the
49 Unaccompanied Children Program that provide health, dental, and mental health care.⁸

1 As mentioned, many asylum seekers claim to have undergone harms in their native country or may
2 undergo harms if deported. A forensic medical evaluation is a specialized exam to document the
3 physical or psychological consequences of such harms. Research indicates that “forensic medical
4 evaluations can provide scientific evidence that a person has suffered persecution and harm,
5 improving the likelihood that those who seek refuge in the United States will be granted asylum or
6 other forms of life-saving immigration relief.”⁹

7
8 *Training for physicians*

9
10 The CDC provides [technical instructions](#) for “panel physicians” who are medically trained,
11 licensed, and experienced physicians practicing overseas and designated by the local U.S. consulate
12 or embassy. These physicians “must follow specific identification procedures, prescribed by the
13 U.S. Department of State, to ensure that the person appearing for the medical examination is the
14 person who is actually applying. The panel physician is responsible for the entire examination,
15 including the required chest radiograph and any necessary laboratory procedures. The panel
16 physician is also responsible for reporting the results of all required tests and consultations on the
17 prescribed forms and for ensuring that the completed medical report forms are sent directly to the
18 consular officer. The panel physician is not responsible for determining whether an applicant is
19 actually eligible to apply to enter the United States; that determination is made by the consular
20 officer after reviewing all records, including the report of the medical examination.”¹⁰ Likewise,
21 the CDC provides [technical instructions](#) for designated “civil surgeons” who perform such medical
22 examinations inside the U.S. The CDC also provides [Overseas Refugee Health Guidance](#) to
23 physicians to help promote healthy resettlement.¹⁰

24
25 *Medical education*

26
27 [Standard 7](#) of the Liaison Committee on Medical Education (LCME), the organization that
28 accredits medical schools, addresses “Curricular Content.” Specifically, 7.1 addresses “Societal
29 Problems” and 7.2 addresses “Structural Competence, Cultural Competence, and Health
30 Inequities.” However, LCME does not dictate how medical schools will interpret these standards
31 nor if they will include information on the needs of asylum seekers. Likewise, the Accreditation
32 Council on Graduate Medical Education’s [Common Program Requirement IV.A.](#) on “Educational
33 Components” states that training be “consistent with the sponsoring institution’s mission, the needs
34 of the community it serves, and the desired distinctive capabilities of its graduates, which must be
35 made available to program applicants, residents, and faculty members” (but does not specify
36 asylum seekers who may be part of the community).¹¹

37
38 DISCUSSION

39
40 A study of U.S. medical students published in 2022 concluded that “medical students at schools
41 with affiliated asylum clinics desire to care for asylum seeker patients but feel unprepared to do so,
42 highlighting an unmet need for formal asylum education in U.S. medical schools.”¹² This point was
43 echoed in a 2024 study that assessed the current state of medical school curricula worldwide.¹³

44
45 Another study evaluated student-run clinics for asylum seekers, revealing “the burgeoning
46 capability of student-run asylum clinics to provide evaluations, a trend that underscores medical
47 students’ ability to significantly impact human rights issues. Student-run asylum clinics are poised
48 to fill an increasingly important role in supporting victims of torture and persecution.”¹⁴ These
49 findings highlight the essential role of human rights and social justice in medical education.

1 Similarly, education is imperative for physicians to assist asylum seekers. A variety of resources
2 and trainings are available for physician and non-physician health care professionals. For example,

- 3 • [Physicians for Human Rights](#) has galvanized an Asylum Network of physicians to provide
4 forensic medical and psychological evaluations to support asylum seekers; training is
5 required, and aids are available.
- 6 • [Center for Health Care Strategies](#) offers education on trauma-informed care.
- 7 • [Center for Victims of Torture](#) provides information about trauma-informed and culturally
8 competent care and clinical interventions.
- 9 • [Asylum Medicine Training Initiative](#) prepares health care professionals in the forensic
10 medical evaluation of persons seeking asylum in the U.S.

11
12 While payment for the provision of legal representation for asylum seekers is outside the scope of a
13 physician, and therefore the AMA, the AMA is supportive of medical-legal partnerships (MLPs)
14 and understands the large role that social resources have in health outcomes for patients. Policy [H-](#)
15 [265.986](#) is of relevance. The AMA Code of Medical Ethics does not provide a direct perspective on
16 physician participation in MLPs, but recognizes they can help physicians carry out the
17 responsibilities and principles articulated in Opinions [1.1.8](#), [8.5](#), [10.8](#), and [11.1.4](#). The [AMA](#)
18 [Journal of Ethics](#) released information on this topic in August 2024.¹⁵ Newly established
19 immigration medical-legal partnerships are being implemented in some states to address the
20 complex needs of asylum seekers; the results of the partnerships would be informative.

21
22 *AMA efforts*

23
24 AMA's Advocacy unit has been actively involved in communicating with the highest levels of
25 government in support of the health and well-being of immigrants, refugees, and asylum seekers. In
26 the last four years alone, letters to the following offices have been drafted and submitted (both
27 alone and in collaboration with other organizations):

- 28 • [March 28, 2024, letter](#) to Centers for Medicare & Medicaid Services (CMS) asking to
29 remove barriers to Medicaid and Children's Health Insurance Program (CHIP) coverage
30 for immigrants.
- 31 • [June 23, 2024, letter](#) to HHS and CMS with comments on the proposed clarifications to
32 eligibility criteria for Qualified Health Plans (QHP) through an Exchange, state-based
33 Basic Health Programs (BHPs), and CHIP as well as some insurance affordability
34 programs.
- 35 • [March 16, 2023, letter](#) to President of the United States and U.S. Department of Homeland
36 Security (DHS) to raise concerns about the consideration of a harmful immigration policy
37 — the reinstating of detention of immigrant families.
- 38 • [October 10, 2022, letter](#) to DHS and HHS to increase research and patient-centered mental
39 health treatment for refugee and migrant populations and provide for safer medical
40 practices and protections for migrant women.
- 41 • [July 12, 2022, letter](#) to U.S. Department of the Treasury and HHS with comment in support
42 of Washington State's Section 1332 Waiver application to cover the uninsured and
43 improve health insurance affordability.
- 44 • [April 22, 2022 letter](#) to DHS with comment on the Public Charge Ground of
45 Inadmissibility proposed rule, opposing any regulations or policy that would deter
46 immigrants and/or their dependents from utilizing non-cash public benefits, including but
47 not limited to Medicaid, CHIP, Special Supplemental Nutrition Program for Women,
48 Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP).
- 49 • [February 2, 2022 letter](#) to the Department of Justice and DHS in opposition to Docket
50 Number USCIS 2020-0013 (Interim Final Rule) on the grounds that it will place asylum

1 seekers in even greater peril and provide DHS and border patrol agents with unwarranted
2 and heightened authority that represents an ineffective way to protect public health while
3 reducing barriers for noncitizens seeking protection in the U.S.

- 4 • [January 13, 2022 letter](#) to the Secretary of State with comment on “Visas: Ineligibility
5 Based on Public Charge Grounds” Docket DOS-2021-0034 and RIN 1400-AE87.1 The
6 AMA strongly opposed any rules, regulations, or policies that would deter immigrants,
7 nonimmigrants, and their dependents from seeking visas or from utilizing noncash public
8 benefits including, but not limited to, Medicaid, SNAP, and housing assistance.
- 9 • [November 29, 2021, letter](#) to DHS with comment on the USCIS proposed rule regarding
10 Deferred Action for Childhood Arrivals (DACA) [DHS Docket No. USCIS–2021–0006]
- 11 • [October 14, 2021, letter](#) to DHS to provide information regarding the Public Charge
12 Ground of Inadmissibility, as the AMA strongly opposed any rules, regulations, or policies
13 that would deter immigrants/nonimmigrants seeking visas and/or their dependents from
14 utilizing non-cash public benefits such as, but not limited to, Medicaid, SNAP, and housing
15 assistance.
- 16 • [September 23, 2021, letter](#) to DHS urging them to ensure the health and well-being of all
17 individuals and their families seeking asylum in the U.S., including the Haitian refugees
18 that were at the U.S. southern border.
- 19 • [September 23, 2020, letter](#) to DHS urging DHS and the Office of the Inspector General
20 (OIG) to thoroughly investigate complaints about detained immigrants’ substandard living
21 conditions and improper health care, including allegations of inadequate informed consent
22 practices.
- 23 • [September 22, 2020, letter](#) to Customs and Border Protection to raise concerns regarding
24 their expiring contract for medical services.
- 25 • [July 16, 2020, letter](#) to DHS to urge U.S. Immigration and Customs Enforcement (ICE) to
26 release all children together with their parents and caregivers from ICE-run Family
27 Residential Centers.

28 29 RELEVANT AMA POLICIES

30
31 AMA Policy [H-350.957](#) “Addressing Immigrant Health Disparities” calls for:

- 32 1. Our American Medical Association recognizes the unique health needs of refugees, and
33 encourages the exploration of issues related to refugee health and support legislation and
34 policies that address the unique health needs of refugees.
- 35 2. Our AMA: (A) urges federal and state government agencies to ensure standard public
36 health screening and indicated prevention and treatment for immigrant children, regardless
37 of legal status, based on medical evidence and disease epidemiology; (B) advocates for and
38 publicizes medically accurate information to reduce anxiety, fear, and marginalization of
39 specific populations; and (C) advocates for policies to make available and effectively
40 deploy resources needed to eliminate health disparities affecting immigrants, refugees or
41 asylees.
- 42 3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including
43 vaccinations in a patient centered, language and culturally appropriate way upon
44 presentation for asylum regardless of country of origin.

45
46 Additional policies that address asylum seekers are listed here and located in Appendix B:

- 47 • [Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951](#)
- 48 • [Oppose Mandatory DNA Collection of Migrants H-65.955](#)
- 49 • [Care of Women and Children in Family Immigration Detention H-350.955](#)

50

1 The AMA has many other policies regarding refugees and immigrants such as:

- 2 • [Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving](#)
- 3 [Mental Health Outcomes for Refugee Women D-345.982](#)
- 4 • [Increasing Access to Healthcare Insurance for Refugee Populations H-350.956](#)
- 5 • [Retraining Refugee Physicians H-200.950](#)
- 6 • [Immigration Status is a Public Health Issue D-350.975](#)
- 7 • [Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services](#)
- 8 [D-440.927](#)
- 9 • [Support of Health Care to Legal Immigrants H-290.983](#)
- 10 • [Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992](#)
- 11 • [Improving Medical Care in Immigrant Detention Centers D-350.983](#)
- 12 • [Care of Women and Children in Family Immigration Detention H-350.955](#)

13
14 CONCLUSION

15
16 The AMA recognizes that there are many facets to the legal U.S. immigration system, including
17 medical evaluation. Asylum seekers are in need of care and assistance, and medical students,
18 trainees, and physicians should play a role in this medical care. The AMA supports opportunities
19 for interested physicians to gain further education and training to care for these patients.

20
21 The Board of Trustees therefore recommends that the following recommendations be adopted and
22 the remainder of this report be filed.

23
24 That Policy [H-350.957](#) be amended by addition and deletion to read as follows:

- 25 3. Our AMA ~~will~~ calls for asylum seekers to receive medically-appropriate care,
- 26 including vaccinations, in a patient centered, language and culturally appropriate way
- 27 upon presentation for asylum regardless of country of origin.
- 28 4. Our AMA supports efforts to train physicians to conduct medical and psychiatric
- 29 forensic evaluations for asylum seekers.
- 30 5. Our AMA supports medical education that addresses the challenges of life-altering
- 31 events experienced by asylum seekers.
- 32 6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
- 33 7. Our AMA encourages physicians to seek out organizations or agencies in need of
- 34 physicians to provide these services.
- 35 8. Our AMA encourages provision of resources to assist people seeking asylum.

36
37
38 Fiscal note: \$1,000

APPENDIX A: GLOSSARY (in alphabetical order)

Alien/Non-citizen/Foreign National

A person who is “not a citizen or national of the United States as the term ‘alien’ is defined in section 101(a)(3) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(3)).” An alien is subject to the host country’s law pertaining to non-citizens.¹

Asylum Seeker/Asylee

A person who is “an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality, membership in a particular social group or political opinion.”¹ They must arrive at or cross a border into the desired country and apply for protection.² An asylum seeker’s claim for refugee status has not yet been legally determined.

Immigrant

A person who “chooses to leave their home country and move to a foreign one to settle there.”² While a “legal immigrant” is foreign-born and legally admitted to the U.S., an “undocumented immigrant” (also called an “illegal alien”) is a foreign-born person who does not possess a valid visa or other immigration documentation.²

Migrant

A person who “is moving from place to place (within his or her country or across borders), usually for economic reasons such as seasonal work”². Like immigrants, they are seeking better opportunities but were not forced to leave their native countries (due to persecution or violence).

Refugee

A person “outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution based on the person’s race, religion, nationality, membership in a particular social group, or political opinion. For a legal definition of refugee, see section 101(a)(42) of the Immigration and Nationality Act.” According to the International Rescue Committee (IRC), a government or the United Nations Refugee Agency determines whether a person seeking international protection meets the definition of a refugee. If one is granted refugee status, they are given protections under international laws and conventions and lifesaving support from aid agencies, including the IRC. Refugees in the U.S. also have the opportunity to become lawful permanent residents and eventually citizens.²

APPENDIX B: RELEVANT AMA POLICIES

[Addressing Immigrant Health Disparities H-350.957](#)

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

[Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951](#)

Our American Medical Association opposes discrimination against Haitian asylum seekers which denies them the same opportunity to attain asylum status as individuals from other nations.

[Oppose Mandatory DNA Collection of Migrants H-65.955](#)

Our American Medical Association opposes the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent.

[Care of Women and Children in Family Immigration Detention H-350.955](#)

1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-24

Subject: Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent (Resolution 009-A-22)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 009, “Privacy
2 Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and
3 Images Without Consent,” which amended Policy H-515.967 as follows:
4

5 Our American Medical Association opposes the publication or broadcast of sexual assault
6 victims' names, addresses, images or likenesses without the explicit permission of the victim.
7 The AMA additionally opposes the publication (including posting) or broadcast of videos,
8 images, or recordings of any illicit activity of the assault. The AMA opposes the use of such
9 video, images, or recordings for financial gain and/or any form of benefit by any entity.
10

11 And further asked our American Medical Association (AMA) to:

12
13 Research issues related to the distribution of intimate videos and images without consent to
14 find ways to protect these victims to prevent further harm to their mental health and overall
15 well-being- (Policy D-515.975).
16

17 This report responds to the call for research.
18

19 BACKGROUND
20

21 The distribution of sexual or pornographic images and videos of individuals without their consent
22 is a growing problem. Such acts include images taken without consent or images taken with
23 consent but later distributed without consent, sometimes referred to as revenge porn, as well as
24 sexually explicit deepfake images or videos of individuals created without their consent. The
25 distribution of intimate videos and images without consent is known as image-based sexual abuse,
26 which is also a form of gender-based violence, as it disproportionately affects women, and the
27 impacts on victims often replicate those of sexual assault [1].
28

29 A 2020 report found that an estimated 1 in 12 adults in the U.S. have been victims of
30 nonconsensual pornography, and that 1 in 20 adults in the U.S. have reported perpetuating such
31 abuse [2]. Additionally, a 2016 report found that young people (ages 15 to 29), LGBTQ+
32 individuals, and those from low-income households are at greater risk of image-based sexual abuse
33 [3]. Research published in 2020 also found that approximately 1 in 5 girls and 1 in 10 boys (ages
34 13 to 17) report sharing their own “nudes,” and 1 in 3 underaged teens report having seen
35 nonconsensual shared nudes of other minors, which legally qualifies as child pornography [4].
36

1 The development of generative AI has accelerated the proliferation of image-based sexual abuse.
2 The creation of nonconsensual deepfake pornography of students by their peers has quickly
3 become a nationwide crisis at schools across the country [5,6]. A 2023 report on the state of
4 deepfakes found that 98 percent of all deepfake videos online were pornographic and that 99
5 percent of such videos were of women [7]. The same report also found a 550 percent rise in the
6 prevalence of deepfakes from 2019 to 2023 and that “[i]t now takes less than 25 minutes and costs
7 \$0 to create a 60-second deepfake pornographic video of anyone using just one clear face image”
8 [7].

9 10 ETHICAL CONCERNS

11
12 The nonconsensual creation and/or distribution of explicit images of a person is a form of sexual
13 violence and is inherently unethical. Sexual violence, which disproportionately affects women and
14 younger people (ages 18 to 34), can have lasting negative health impacts, including increased risk
15 of Post Traumatic Stress Disorder (PTSD), substance abuse, and suicide [8]. In addition to the
16 physical and mental harms, those who experience image-based sexual abuse may also suffer from
17 social, emotional, and existential harms, such as social rupture, isolation, and constrained liberty
18 [9,10]. In addition to the harms such acts of abuse may cause, they also constitute wrongs that
19 violate individuals’ rights to dignity, privacy, autonomy, and freedom of sexual expression [10].

20 21 DISCUSSION

22
23 Confidentiality laws, which protect individuals’ choices about sharing information, and privilege
24 laws, which prohibit the sharing of private information without an individual’s consent, vary from
25 state to state. As of May 2024, only 20 states have enacted laws addressing nonconsensual sexual
26 deepfakes [11]. There is currently no federal law against image-based sexual abuse.

27
28 There is currently a lack of accountability when it comes to the regulation of nonconsensual
29 sexually explicit images. The federal 1996 Communications Decency Act that regulates
30 pornography on the internet protects websites and service providers from liability for content
31 posted by users with whom they are not co-creators. According to Section 230 of the Act, operators
32 of internet services and websites, including social media, are not considered publishers of content
33 their users post, and as such, have no legal obligation to remove nonconsensual pornography unless
34 it otherwise violates copyright or federal criminal laws [12].

35
36 On May 23, 2024, the White House released “A Call to Action to Combat Image-Based Sexual
37 Abuse,” calling on Congress and the technology sector to work to manage the risks of AI and to
38 strengthen protections for survivors and victims of image-based sexual abuse, including those
39 generated by AI [13]. One proposed approach to strengthen protections has been to craft an
40 amendment to the Violence Against Women Act, which protects survivors of sexual assault and
41 domestic violence, to give victims the right to sue in civil court those who create, solicit, possess,
42 and distribute nonconsensual AI-generated pornography [14].

43
44 Technology Safety, a national network to end domestic violence, has created a [Confidentiality](#)
45 [Toolkit](#) with resources such as survivor confidentiality releases, information on federal
46 confidentiality laws, and access to online coordinated care networks and referral systems [15]. [The](#)
47 [National Network to End Domestic Violence](#) has also created a series of educational tools and
48 online toolkits that focus on the intersections of technology and domestic and sexual violence [16].
49 Similarly, Cyber Civil Rights Initiative (CCRI) is an online organization that provides support for
50 revenge porn survivors, including resources such as attorney referrals, a crisis hotline, and a guide

1 for helping remove photos from the internet [17]. The Digital Millennium Copyright Act website
2 also can help with taking down images [18].

3
4 The recent White House “Call to Action” lists actions that the private sector should take, such as
5 disrupting the monetization of image-based sexual abuse by curbing access to payment services for
6 the sites or apps that host such images, as well as encouraging institutional requirements for app
7 developers to work towards preventing their creation in the first place. A 2020 international report
8 found that men and young people are more commonly perpetrators of image-based sexual abuse,
9 which suggests that targeted public health educational initiatives may be an effective tool to reduce
10 such abuse [19].

11 12 RELEVANT AMA POLICY

13
14 Our AMA has several relevant policies including AMA *Code of Medical Ethics* [Opinion 8.10](#),
15 “Preventing, Identifying and Treating Violence and Abuse.” Among the directives of the opinion,
16 physicians are told that they should become familiar with how to detect violence or abuse and the
17 resources available for abused or vulnerable persons; routinely inquire about physical, sexual, and
18 psychological abuse as part of the medical history; not allow diagnosis or treatment to be
19 influenced by misconceptions about abuse; and treat the immediate symptoms and sequelae of
20 violence and abuse and provide ongoing care for patients to address long-term consequences that
21 may arise. The 2023 AMA article “You suspect a patient is being abused. What should you do?”
22 provides physicians with information and links to relevant resources, including information on the
23 importance of providing trauma-informed care and recognizing that not all patients may choose to
24 disclose abuse, even when screened [[20](#)].

25
26 AMA policies that address sexual assault include [H-515.953](#), “Sexual Assault Education and
27 Prevention in Public Schools,” [H-515.956](#), “Addressing Sexual Assault on College Campuses,” [H-](#)
28 [515.967](#), “Protection of the Privacy of Sexual Assault Victims,” and [D-515.976](#), “Advocacy on the
29 US Department of Education’s Spring 2022 Title IX Rules on Sexual Harassment and Assault in
30 Education Programs.” These policies tend to focus on sexual assault rather than sexual violence,
31 which is a more encompassing, non-legal term that covers sexual assault, harassment, and abuse.
32 Our AMA may want to consider adopting the broader term “sexual violence” in place of “sexual
33 assault” in most cases.

34 35 CONCLUSION

36
37 Advances in digital technologies including generative AI have facilitated the distribution of
38 intimate videos and images without consent, and thus sexual violence overall. Physicians should be
39 familiar with how to identify signs of sexual violence, how to treat the immediate and long-term
40 consequences of sexual violence, and how to prevent further harm to their patients’ mental and
41 overall health. In addition, more public and private sector efforts to address image-based sexual
42 violence are needed.

43 44 RECOMMENDATIONS

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

- 48
49 1. That our American Medical Association (AMA) encourage the development of public
50 and private sector initiatives to prevent and address image-based sexual violence. (New
51 HOD Policy)

- 1
2. That Policy D-515.975 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal – less than \$500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-24

Subject: Expanding Protections of End-of-Life Care
(Resolution 722-A-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 722, “Expanding
2 Protections of End-of-Life Care,” authored by the New York Delegation which asks our American
3 Medical Association (AMA):

- 4
- 5 (1) recognizes that health care, including end of life care like hospice, is a human right,
6
- 7 (2) supports the education of medical students, residents and physicians about the need for
8 physicians who provide end of life health care services,
9
- 10 (3) supports the medical and public health importance of access to safe end of life health care
11 services and the medical, ethical, legal and psychological principles associated with end-
12 of-life care,
13
- 14 (4) supports education of physicians and lay people about the importance of offering
15 medications to treat distressing symptoms associated with end of life including dyspnea, air
16 hunger, and pain,
17
- 18 (5) will work with interested state medical societies and medical specialty societies to
19 vigorously advocate for broad, equitable access to end-of-life care,
20
- 21 (6) supports shared decision-making between patients and their physicians regarding end-of-
22 life health care,
23
- 24 (7) opposes limitations on access to evidence-based end of life care services,
25
- 26 (8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against
27 physicians for receiving, assisting in, referring patients to, or providing end of life health
28 care services.
29

30 This report provides relevant background, discussion, and recommendations.

31
32 **BACKGROUND**

33
34 The leading causes of death in the United States are associated with chronic illness in which the
35 patient experiences long durations of symptom burden, medical treatments and interventions, and
36 diminished quality of life [1]. As chronic illness progresses to serious and critical illness, death

1 may be anticipated; however, patients and their families are often unprepared for the emotional
2 burden of making life-sustaining and/or prolonging medical decisions during treatment of serious
3 and critical illness [2]. As a result, many patients experience physical suffering and receive life-
4 sustaining and/or prolonging medical treatments and interventions that are not in accordance with
5 their preferences, values, and goals [3]. Additionally, patients and their families commonly
6 experience emotional suffering including anxiety and depression [2]. The health care team plays a
7 crucial role in alleviating the burden of physical and existential suffering during serious and critical
8 illness and end-of-life through the delivery of palliative care.

9
10 Palliative care is the comprehensive management and coordination of care for pain and other
11 distressing symptoms, including physical, psychological, intellectual, social, psychosocial,
12 spiritual, and existential consequences of a serious illness, which improves the quality of life of
13 patients and their families/caregivers. Additionally, palliative care evaluation and treatments are
14 patient-centered, with a focus on the central role of the family unit in shared decision-making
15 according to the needs, values, beliefs, and culture or cultures of the patient and their family [4].
16 Importantly, palliative care can be offered in all care settings through a collaborative team
17 approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers,
18 therapists, pharmacists), should be available at any stage of illness from birth to advanced age, and
19 may be offered simultaneously with disease-modifying interventions, including attempts for cure or
20 remission [5, 6]. However, palliative care is especially suited for persons who have incurable,
21 progressive illness and are facing end-of-life. Hospice, which is a part of palliative care, is offered
22 when a patient is eminently dying [7].

23
24 Palliative care can be delivered by any physician, in any specialty; however, specialty palliative
25 care can be provided by consultants when the patient and/or their family's needs are more complex
26 [6]. Integration of palliative care into the patient's care plan has many well studied benefits
27 including, improved quality of life, decreased symptom burden, increased goal-concordant care,
28 increased caregiver support, reduced anxiety, decreased hospital mortality, and reductions in
29 unnecessary medical costs [8]. Additionally, early integration of palliative care reduces
30 unnecessary medications and procedures that have the potential to elicit unwanted side effects or
31 complications and, in some cases, lengthens survival while also decreasing suffering [9,10].
32 Although palliative care is especially suited for persons who have incurable, progressive illness and
33 are facing end-of-life, it is imperative to distinguish the delivery and purpose of palliative care
34 from any action that intentionally causes death, including physician assisted suicide and euthanasia.
35 While palliative care provides pain and symptom management as well as assistance with making
36 difficult medical decisions and emotional support to patients during end-of-life, palliative care
37 interventions never intentionally cause death.

38
39 Numerous AMA policies ([H-295.875, Palliative Care and End-of-Life Care](#); [H-70.915 Good](#)
40 [Palliative Care](#); [D-295.969, Geriatric and Palliative Care Training for Physicians](#)) support the
41 provision of palliative care for patients and the education on palliative care for physicians. The
42 AMA is not alone in its support of palliative care. The World Health Assembly (WHA) declared
43 that providing palliative care should be considered an ethical duty for health organizations [11].
44 Additionally, the World Health Organization (WHO) declared that palliative care is an ethical duty
45 of health professionals, and, in 2012, the United Nations Office of the High Commissioner for
46 Human Rights recognized that the failure to provide palliative care and end-of-life care to older
47 persons is a human rights violation [11,12]. Furthermore, in 2011, the World Medical Association
48 (WMA) adopted the *Declaration on End-of-life Medical Care* which declared that "The objective
49 of palliative care is to achieve the best possible quality of life through appropriate palliation of pain
50 and other distressing physical symptoms, and attention to the social, psychological and spiritual
51 needs of the patient" and is part of good medical care [13]. Three years later, the WMA further

1 expanded their support of palliative care with the adoption of a resolution that called for the
2 integration of palliative care in global disease control and health system plans. Additionally, major
3 world religions also endorse palliative care [14].

4
5 The AMA recognizes the disparities in access to palliative care services, especially among racial,
6 ethnic, and socioeconomically disadvantaged populations. Ensuring all patients, regardless of
7 background or geography, receive equitable, culturally competent, and appropriate palliative care is
8 essential.

9 10 DISCUSSION

11
12 Despite a strong evidence basis supporting the benefits of palliative care, and existing AMA and
13 international medical policies supporting palliative care as an ethical and imperative part of high-
14 quality medical care, millions of patients within the United States experience barriers to accessing
15 palliative care due to misconceptions, misinformation, limited resource availability, and inaccurate
16 stigma surrounding the definition of palliative care and its scope [5,11,15,16]. Additionally, due to
17 these same misconceptions and stigma, physicians face barriers to receiving education and
18 providing palliative care at all stages of the disease course [17,18].

19
20 While AMA Policy and the *Code of Medical Ethics* ([Opinion 5.2: Advance Directives](#); [Opinion](#)
21 [5.3: Withholding or Withdrawing Life-Sustaining Treatment](#)) historically support addressing the
22 palliative needs of patients and assert that clinicians have a duty to provide optimal palliative care
23 to patients, our AMA has not provided specific guidance on the definition, delivery, and scope of
24 high-quality palliative care.

25
26 First, although the concept of palliative care is referenced throughout AMA policy, it is often
27 inaccurately labeled as end-of-life care and no specific definition is provided as to what the ethical
28 provision of this care entails or the scope of this practice. Defining palliative care is essential given
29 that palliative care is often misunderstood and misattributed. Second, expanding palliative care
30 education and access is important for ensuring that patients are able to obtain these evidence-based
31 health care interventions during any stage of their serious or critical illness, including end-of-life
32 care. Palliative care should be offered concurrently with disease modifying interventions, including
33 attempts for cure or remission. Thirdly, palliative care, which is an ethical duty, should be
34 distinguished from other practices that are considered ethically questionable or unethical in the
35 practice of medicine by the AMA *Code of Medical Ethics* (e.g., knowingly and intentionally
36 hastening or causing death, physician assisted suicide, and euthanasia). Lastly, advocating for
37 expanding access to palliative care, as well as legal protections for physicians who provide this
38 essential component of high-quality patient care are important.

39 40 CONCLUSION

41
42 Palliative care is an evidence based, essential component of serious illness, critical illness, and end-
43 of-life care that is often inaccurately defined, misrepresented, and neglected. As a result, patients
44 and their families endure physical and existential suffering that could be mitigated or alleviated
45 with palliative care intervention. Barriers to physicians providing, and patients receiving palliative
46 care may be alleviated through reaffirming existing AMA policy on education and new AMA
47 policy providing guidance on the definition, delivery, and scope of palliative care.

48 49 50 51 RECOMMENDATION

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In light of these considerations, the Board of Trustees Report 18 reaffirms H-295.825, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians; and recommends that alternate Resolution 722, “Expanding Protection of End-of-Life Care,” be adopted in lieu of Resolution 722 and this report be titled “Expanding Palliative Care” and the remainder of this report be filed:

Our American Medical Association:

- (1) recognizes that access to palliative care, including hospice, is a human right.
- (2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers and that palliative care evaluation and that palliative care treatments are patient-centered and family-oriented., emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family.
- (3) recognizes that palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists) and should be available at any stage of a serious illness from birth to advanced age and may be offered simultaneously with disease modifying interventions.
- (4) recognizes that hospice is a specific type of palliative care, reserved for individuals with a prognosis of six months or less who have chosen to forego most life-prolonging therapies, whereas palliative can be offered alongside curative or life-prolonging treatments at any stage of illness.
- (5) recognizes that palliative care differs from physician assisted suicide in that palliative care does not intentionally cause death. In fact, palliative treatments that relieve symptom distress have been shown in numerous studies to prolong life.
- (6) will work with interested state medical societies and medical specialty societies and vigorously advocate for broad, equitable access to palliative care, including hospice, to ensure that all populations, particularly those from underserved or marginalized communities have access to these essential services.
- (7) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for assisting in, referring patients to, or providing palliative care services, including hospice.

(New HOD Policy)

Fiscal Note: Minimal – Less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-24

Subject: Resolution Deadline Clarification

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD), the HOD adopted CCB Report 6 that included bylaw language to implement a change to
3 resolution deadlines. CCB Report 6-A-24 derived from the adopted as amended recommendations
4 in Speakers Report 1-A-24. The HOD voted to retain the existing exception for Section resolutions
5 that was initially proposed for deletion. The adopted language is follows:

6 7 **2.11.3 Introduction of Business.**

8
9 **2.11.3.1 Resolutions.** To be considered as regular business, each resolution
10 must be introduced by a delegate or organization represented in the
11 House of Delegates and must have been submitted to the AMA not later
12 than 45 days prior to the commencement of the meeting at which it is to
13 be considered, with the following exceptions.

14
15 **2.11.3.1.1 AMA Sections.** Resolutions presented from the business
16 meetings of the AMA Sections may be presented for
17 consideration by the House of Delegates no later than the
18 recess of the House of Delegates opening session to be
19 accepted as regular business. Resolutions presented after
20 the recess of the opening session of the House of
21 Delegates will be accepted in accordance with Bylaw
22 2.11.3.1.3.

23
24 **2.11.3.1.2 Late Resolutions.** Late resolutions may be presented by a
25 delegate any time after the 45-day resolution deadline
26 until the opening session of the House of Delegates, and
27 will be accepted as business of the House of Delegates
28 only upon two-thirds vote of delegates present and voting.

29
30 **2.11.3.1.3 Emergency Resolutions.** Resolutions of an emergency
31 nature may be presented by a delegate any time after the
32 opening session of the House of Delegates. Emergency
33 resolutions will be accepted as business only upon a three-
34 fourths vote of delegates present and voting, and if
35 accepted shall be presented to the House of Delegates
36 without consideration by a reference committee. A simple
37 majority vote of the delegates present and voting shall be
38 required for adoption.

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2.11.3.1.4 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.5 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

Following the A-24 HOD meeting, there were concerns raised about how the "section exception" in Bylaw 2.11.3.1.1 would be applied to those sections with resolution ratification processes not occurring immediately prior to the HOD meetings. Therefore, the Council has prepared clarifying bylaw language for consideration by the HOD to include all section resolutions that are ratified prior to a HOD meeting and within the 45 day window in this singular exception to on-time resolutions. Additionally, the Council offers further clarifying edits to better delineate on-time, late and emergency resolutions.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following recommendation be adopted, and that the balance of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

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

2.11.3 Introduction of Business.

2.11.3.1 Resolutions.

2.11.3.1.1 On-Time Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 45 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1.1 AMA Sections. Resolutions presented from ~~the business~~ meetings of the AMA Sections convened prior to the coinciding House of Delegates meeting but after the 45 day on-time deadline may be presented for consideration by the House of Delegates upon adoption by the Section and no later than the commencement recess of the House of Delegates opening session to be accepted as regular business. Section ~~R~~resolutions presented after the commencement recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.3.

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2.11.3.1.2 Late Resolutions. Late resolutions may be presented by a delegate or organization represented in the House of Delegates any time after the 45-day resolution deadline until the commencement of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.3 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the commencement of the opening session of the House of Delegates. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be ~~presented to~~ considered by the House of Delegates without ~~consideration~~ deliberation by a reference committee. ~~A simple majority vote of the delegates present and voting shall be required for adoption.~~

(Modify Bylaws)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-24

Subject: Name Change for Reference Committee

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 American Medical Association (AMA) Bylaw 2.13.1.1, Amendments to the Constitution and
 2 Bylaws. states that "All proposed amendments to the Constitution or Bylaws, and matters
 3 pertaining to the Principles of Medical Ethics of the AMA shall be referred to this committee." This
 4 is the only reference committee cited in the AMA Bylaws. Its name, however, when listed in the
 5 online reference committee, on resolutions and reports, or in the House of Delegates Handbook
 6 implies that that the reference committee focuses exclusively on items related to amendments to the
 7 Constitution or Bylaws.

8
 9 To more appropriately convey the focus of this reference committee and minimize confusion about
 10 its purpose, the Speakers have requested the Council to consider proposing a name change. The
 11 Council considered this request, and has proposed a bylaw amendment to rename this committee
 12 more appropriately as the Reference Committee on Ethics and Bylaws. The Council believes this
 13 bylaw change will provide needed clarity to Delegates and reference committee members alike as
 14 to the scope of matters considered by this committee.

15 RECOMMENDATIONS

16
 17
 18 The Council on Constitution and Bylaws recommends that the following recommendation be
 19 adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of
 20 two-thirds of the members of the House of Delegates present and voting following a one-day
 21 layover:

22
 23 1) That our AMA Bylaws be amended by insertion and deletion as follows:

24 **2.13 Committees of the House of Delegates.**

25 **2.13.1 Reference Committees of the House of Delegates.**

26
 27
 28
 29 **2.13.1.1 Ethics and Amendments to the Constitution and Bylaws.** All
 30 ~~proposed amendments to the Constitution or Bylaws, and matters pertaining to~~
 31 ethics, the Principles of Medical Ethics of the AMA and to the AMA
 32 Constitution and Bylaws shall be referred to this committee.

33
 34 (Modify Bylaws)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-24

Subject: Bylaw Amendments to Address Medical Student Leadership
(Resolution 003-A-24)

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2024 Annual Meeting of the House of Delegates (HOD) of the American Medical
2 Association (AMA), the HOD adopted Resolution 3 as amended submitted by the Medical Student
3 Section: "That our American Medical Association modify the current 90-day post-graduation
4 eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical
5 students to serve on the Medical Student Section Governing Council, on the AMA Board of
6 Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to
7 200 days after graduation and not extending past the Annual Meeting following graduation" (Policy
8 D-605.985). The intent of the adopted language was to accommodate those medical students who
9 graduate off-cycle.

10
11 The Council has prepared the appropriate bylaw amendments for HOD action. The Council has
12 also added amended bylaw language to encompass the medical student member of the newly
13 formed LGBTQ+ Section.

14 15 RECOMMENDATIONS

16
17 The Council on Constitution and Bylaws recommends that the following recommendation be
18 adopted; that Policy D-605.985 be rescinded; and that the remainder of this report be filed.
19 Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates
20 present and voting following a one-day layover:

21
22 1) That our AMA Bylaws be amended by insertion and deletion as follow:

23 24 **3 Officers**

25
26 ***

27 **3.5.6 Medical Student Trustee.** The Medical Student Section shall elect the medical student
28 trustee annually. The medical student trustee shall have all of the rights of a trustee to
29 participate fully in meetings of the Board, including the right to make motions and to
30 vote on policy issues, intra-Board elections or other elections, appointments or
31 nominations conducted by the Board of Trustees.

32
33 **3.5.6.1 Term.** The medical student trustee shall be elected at the Business Meeting of
34 the Medical Student Section prior to the Interim Meeting for a term of one
35 year beginning at the close of the next Annual Meeting and concluding at the

close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. 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 during their term, within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees for up to 200 days after graduation but not extending past the Annual Meeting following graduation. until completion of the Annual Meeting.

6 Councils

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

7 Sections

7.3 Medical Student Section. The Medical Student Section is a fixed Section.

7.3.1 Membership. All active medical student members of the AMA shall be members of the Medical Student Section.

7.3.2 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program during their term within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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7.7 Minority Affairs Section. The Minority Affairs Section is a delineated Section.

7.7.3.1 Section Representatives on the Governing Council. 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 they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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

7.10.3.1 Section Representatives on the Governing Council. 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 they cease to meet the membership requirement of the respective section. If any representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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

7.12.2.3 If any ~~medical student~~, resident/fellow or young physician member of the governing council ceases to meet the criteria for membership in the section they represent within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If any medical student member graduates from an educational program during their governing council term, such medical student shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

(Modify Bylaws)

Fiscal Note: Less than \$500

RELEVANT AMA POLICY

D-605.985, Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity. Our American Medical Association will modify the current 90-day post-graduation eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-24)
Expanding Access to Palliative Care
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Palliative care focuses on improving quality of life by providing physical and emotional support to the patient and their family during serious and critical illness. Failure to provide palliative care is in direct conflict with the well-established ethical duty for physicians to relieve the pain and suffering of their patients. Although the term “palliative treatment” is referred to in both the *Code of Medical Ethics (Code)* and numerous House of Delegates policies, the ethical provision of this medical practice is neither discussed nor defined in house policies or in the *Code*. This Council on Ethical and Judicial Affairs (CEJA) report recommends the adoption of a new opinion in the *Code* which addresses the ethical provision of palliative care.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-24

Subject: Expanding Access to Palliative Care

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1

2 BACKGROUND

3

4 The majority of deaths in the United States result after months to years of treating complications of
5 underlying chronic illness and comorbidities, including cancer, heart disease, and stroke [1].
6 Although many deaths in America are anticipated, patient preferences, values, and goals for
7 medical treatment during serious and critical illness are not often elicited prior to the initiation of
8 life sustaining interventions including mechanical ventilation, artificial nutrition and hydration, and
9 cardiopulmonary resuscitation [2]. The stress and uncertainty surrounding medical decisions during
10 serious illness often results in patients and their families experiencing needless physical and
11 emotional suffering such as anxiety, depression, and the prolonged use of unwanted or likely to be
12 ineffective mechanical and pharmacological life sustaining interventions that cannot restore the
13 patient to an acceptable level of health and function [3]. The patient and their family’s experience
14 of suffering during their serious illness is often avoidable or mitigatable by physicians through
15 palliative care [3].

16

17 Palliative care focuses on improving quality of life by providing physical and emotional support to
18 the patient and their family during serious and critical illness [4]. Palliative care can be provided at
19 any point in the illness trajectory by any physician, in any specialty (a.k.a. primary palliative care)
20 [5]. When the patient’s and/or their family’s needs are more complex, specialty palliative care can
21 be consulted [5]. [Opinion 5.3](#) of the *Code of Medical Ethics (Code)* calls for the provision of
22 palliative care, which is appropriate when patient or family distress, physical and psychological
23 symptom burden, uncertainty about what to expect in the future, or spiritual/existential distress is
24 identified. Failure to provide palliative care is in direct conflict with the well-established ethical
25 duty for physicians to address the pain and suffering of their patients [6]. Furthermore, American
26 Medical Association (AMA) policy [H-70.915](#) encourages the provision of “good palliative care”
27 and “encourages all physicians to become skilled in palliative medicine.” [Opinion 5.3](#),
28 “Withholding and Withdrawing Life-Sustaining Treatment,” calls for the provision of palliative
29 care when such transitions in care are considered. Additionally, a 1991 Council on Ethical and
30 Judicial Affairs (CEJA) Report was adopted entitled “Decisions Near End of Life” which
31 advocated for the use of palliative care [7].

32

33 Although there is a strong basis supporting the provision of palliative care for patients facing
34 serious illness, the *Code* does not address the ethical provision of palliative care for serious or
35 critical illness. This gap should be filled by the creation of a new opinion which describes 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 ethical provision of “good palliative care” and provides ethical guidelines for implementing
2 palliative care during clinical practice.

3 4 RELEVANT LAW(S)

5
6 There are several definitions of palliative care from the Centers for Medicare and Medicaid
7 Services (CMS), the World Health Organization, the World Medical Association, and the Center to
8 Advance Palliative Care. Common elements include physical and psychological symptom
9 management, focusing on the patient and caregivers as the unit of care, provision throughout the
10 course of the illness, and continuity of care across settings and over time. Reimbursement for
11 palliative care is funded through the CMS as well as other insurers [8]. Also, the Palliative Care
12 and Hospice Education Training Act (PCHETA) is under consideration in the Senate and has been
13 introduced with bipartisan support and the official support of over 90 national and state
14 organizations [9]. PCHETA would create and promote education programs, research programs, and
15 public education programs to support and expand the palliative care workforce, delivery of
16 palliative care, and public awareness about palliative care. In support of furthering the evidence
17 base for palliative medicine, the National Institutes of Health recently established a Consortium for
18 Palliative Care Research Across the Lifespan, a cross-institute funding initiative with an annual
19 commitment of approximately \$12 million [10].

20 21 RELEVANT POLICY PROVISION(S)

22
23 Numerous AMA policies support the provision of palliative care for patients and the education of
24 palliative care for physicians. AMA policy [H-140.966](#) states that “physicians have an obligation to
25 relieve pain and suffering and to promote the dignity and autonomy of patients in their care.
26 Furthermore, policy encourages the provision of “good palliative care” and “encourages all
27 physicians to become skilled in palliative medicine.” [H-295.875](#) encourages “the inclusion of
28 palliative medicine in the core curriculum of undergraduate and graduate medical education” and
29 the “use of palliative care techniques and interdisciplinary team care.” [D-295.969](#) “encourages
30 palliative training for physicians caring for elderly and terminally ill patients in long-term care
31 facilities.” [H-85.949](#) supports “increased access to comprehensive interdisciplinary palliative care
32 services by Medicare patients.” [H-55.999](#) “supports palliative care procedures for cancer patients.”

33 34 RELEVANT *CODE* PROVISION(S)

35
36 The *Code* references and supports the provision of palliative care numerous times. For example,
37 Opinions [5.3](#) and [6.1.2](#) both require physicians to “ensure that relevant standards for good clinical
38 practice and palliative care are followed when implementing any decision to withdraw a life-
39 sustaining intervention” and Opinion [5.6](#) requires physicians to consult “an expert in the field of
40 palliative care, to ensure that symptom-specific treatments have been sufficiently employed” prior
41 to engaging in palliative sedation to unconsciousness. Additionally, Opinions [2.2.5](#) and [5.2](#) mention
42 palliative interventions; however, the *Code* does not directly address what qualifies as palliative
43 care, nor does it provide ethical guidance on the delivery of palliative care.

44 45 ETHICAL ISSUES

46
47 Delivering palliative care during clinical practice is inextricably linked with navigating ethical
48 dilemmas. For example, physicians must balance the often-competing values, preferences, and
49 goals of the patient, the health care entity, the clinical care team, the payer, and their surrogate or
50 support persons while making complex medical decisions such as when to withhold or withdraw
51 life sustaining interventions or when to counsel cessation of ‘curative’ treatments that become

1 ineffective or harmful [3,11]. These competing values, preferences, and goals arise from many
2 sources including the profession itself, society, community, family, religious beliefs, and personal
3 desires and experience. While navigating various perspectives and competing values during
4 palliative care delivery, physicians must also balance complex ethical questions such as when it is
5 ethically appropriate to withhold or withdrawal life sustaining interventions or provide sedation or
6 analgesia to relieve symptom distress when the unintended potential effect is hastened death. The
7 concept of double effect permits, under appropriate conditions medical treatments or interventions
8 that could have the effect of hastening death so long as the primary intention of providing the
9 medical treatment or intervention is not to hasten death but is for some other clinically and
10 ethically appropriate reason such as pain and symptom management.

11
12 Many of the ethical complexities of palliative care are discussed in detail within the 1991 CEJA
13 report entitled “Decisions Near End of Life”; however, guidance regarding ethical palliative care is
14 absent within the *Code* [7]. This is problematic for several reasons. Importantly, palliative care as a
15 discipline has substantially evolved since 1991 when it was first recognized as a medical specialty.
16 Despite the rapid evolution of palliative care as a medical specialty, the ethical issues highlighted
17 in the 1991 report remain; however, the understanding of palliative care and the role palliative care
18 plays in resolving ethical dilemmas has evolved. Additionally, palliative care is often
19 misunderstood as being limited to comfort care for patients imminently facing end of life. This
20 misunderstanding often results in palliative care being initiated late in the disease course and
21 typically only after the decision to discontinue curative or life prolonging interventions [12].
22 Additionally, this misunderstanding often results in palliative care not being offered concurrently
23 with curative treatments, even for patients with substantial distress during a serious or complex
24 critical illness. Furthermore, due to the underutilization of palliative care throughout the full course
25 of the patient’s illness trajectory, patients are too often referred for palliative care consultation prior
26 to imminent death, and thus, often receive high burden life sustaining interventions where burden
27 outweighs benefit [13,8]. This is problematic because delaying the provision of palliative care
28 results in patients and their families facing unnecessary suffering which is in direct conflict with a
29 physician’s ethical duty to relieve pain and suffering. Providing ethical guidance in the *Code* will
30 help alleviate misnomers and barriers to implementing and practicing ethical palliative care during
31 clinical practice.

32 33 RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

34
35 Amending the *Code* to include ethical guidance on providing palliative care for patients facing
36 serious, chronic, complex, or critical illness will positively affect clinical practice. First, the
37 benefits of palliative care have been well studied and include improved quality of life, decreased
38 symptom burden, increased goal-concordant care, increased caregiver support, reduced anxiety,
39 decreased hospital mortality, and reductions in unnecessary medical costs [14]. In some cases, it
40 may even result in longer survival than those treated with chemotherapy [15]. Second, palliative
41 care improves the quality of care the patient (and their care partners) receives, while providing
42 support for the physician and their team and has been associated with both improved physician
43 satisfaction and patient satisfaction. Third, serious and critical illness care is often a source of stress
44 for physicians and has been associated with physician burn out [13]. Palliative care provides
45 support to physicians in four important ways through the provision of: 1) dedicated time for
46 intensive family meetings and goals of care conversations; 2) skilled communication over time to
47 help patients and their families determine the medical treatment options that match their
48 preferences, values, and goals as illness evolves; 3) expert pain and symptom management of both
49 physical, emotional, social, and spiritual distress; and 4) comprehensive coordination of
50 communication among all providers involved in the patients care [5,14,11].

1 REVIEW OF RELEVANT LITERATURE

2
3 Most people will experience death in a hospital or health care facility after suffering from a chronic
4 serious illness, and one-in-three of the deaths that occur in the hospital will result from a decision
5 to withdraw life-sustaining interventions [12,16-19]. Although it is common for Americans to die
6 in a hospital or health care facility and receive life prolonging interventions at the end of life, this is
7 not how most healthy Americans report that they want their lives to end. This is likely related to
8 multiple factors: the aim of preserving life; the rational assumption that patients and families hold
9 that doctors would not recommend treatments they did not believe to be helpful to the patient so
10 they accede to the doctor's recommendations; and the fact that when death is imminent, patient
11 (and caregiver) desire to hold on often strengthens (this is evident in the observation that despite
12 presence of advance directives specifying comfort measures when recovery is not possible, they are
13 seldom honored) [20]. Evidence is clear that regardless of prognosis and treatments, patients and
14 caregivers living with serious, chronic, complex, and critical illness experience anxiety, depression,
15 and physical and spiritual/existential suffering [11]. One way to remediate this experience is
16 through the provision of palliative care, which is associated with improved quality of life, reduced
17 suffering, and reduced hospital mortality [5,14].
18

19 Palliative care is the comprehensive management and coordination of care for pain and other
20 distressing symptoms including physical, psychological, intellectual, social, psychosocial, spiritual,
21 and existential consequences of a serious illness that improves the quality of life of patients and
22 their families/caregivers [5]. The evaluation and treatment are patient-centered, with a focus on the
23 central role of the family unit in decision-making according to the needs, values, beliefs, and
24 culture of the patient and his or her family [14]. Palliative care can be offered in all care settings,
25 by any physician, and at any stage in a serious illness. The provision of palliative care by
26 physicians without subspecialty training in palliative medicine is known as primary palliative care
27 [5]. When a patient and/or their family's needs become complex, specialty palliative care can be
28 delivered through a collaborative team approach involving all disciplines optimally including
29 physicians, nurses, social workers, spiritual care providers, therapists, and pharmacists. Specialist
30 level palliative care teams work alongside the primary treating team as an added layer of support
31 for all- patient, caregivers, and clinicians.
32

33 Hospice is a mode of palliative care for patients in their homes or long-term care facilities provided
34 in the U.S. with a specific Medicare payment model. Eligible U.S. patients must have an expected
35 prognostic life-expectancy of six months or less and agree to give up regular Medicare insurance
36 coverage. Most private insurers in the U.S. follow the Medicare model for patients not on
37 Medicare. Hospice care is predominantly provided at home or in nursing homes. In contrast,
38 palliative care has no prognosis or treatment restrictions (delivered at any age, any stage, any
39 setting and whether the illness is curable chronic or progressive) and is provided (depending on
40 local capacity) in any setting- hospital, office, cancer center, dialysis unit, home, or long-term care
41 facility [8]. While patients usually receive palliative care concurrently with traditional medical
42 treatments, hospice care focuses on comfort measures for the patient and their family near the end
43 of life. Comfort measures focus on relieving the stress, anxiety, and physical pain which often
44 occurs during the dying process.
45

46 The use of complex disease-specific interventions at the end of life is associated with stress and
47 uncertainty and often results in patients and their families experiencing physical and existential
48 suffering such as intractable pain, anxiety, and depression [13]. The patients and their families'
49 experience of suffering is often avoidable or mitigatable through palliative care [5,14,13]. Although
50 the provision of palliative care is associated with improved quality of life, more days at home, and
51 reduced suffering, palliative care is too often initiated as a last resort, after disease-specific

1 interventions have become ineffective (i.e. futile or unable to result in a beneficial outcome), and
2 the decision to withdraw life sustaining interventions either needs to be made or has already been
3 made [13]. Due to the underutilization of palliative care throughout the full course of the patient's
4 illness trajectory, patients are too often referred for palliative care consultation prior to imminent
5 death, and thus, often receive high burden life sustaining interventions where burden outweighs
6 benefit [13,8].

7 8 ETHICAL ANALYSIS

9 10 *Palliative Care is the Evidence Based Standard of Care for Patients with Serious and Critical* 11 *Illness*

12
13 The need to address palliative care in the *Code* is not a novel concept. At the 1991 Annual Meeting
14 of the House of Delegates (HOD), CEJA Report was adopted entitled "Decisions Near End of
15 Life" which addressed palliative care as an ethical medical intervention [7]. Since the adoption of
16 the CEJA report "Decisions Near End of Life", the HOD passed policy [H-70.915](#) entitled "Good
17 Palliative Care" in 2014. This policy "encourages all physicians to become skilled in palliative
18 medicine" and "encourages education programs . . . in care of the dying patient." Additionally, this
19 policy advocates for reimbursement of palliative care services and research to improve the field of
20 palliative medicine. This policy has been reaffirmed three times since it was originally passed
21 showing the continued interest and support of palliative care in the AMA HOD. In addition to the
22 HOD policy on Good Palliative Care, the HOD has passed eight other policies which have
23 affirmatively advocated for providing palliative care.

24
25 The AMA HOD is not alone in its support of palliative care. The World Health Assembly (WHA)
26 declared that providing palliative care should be considered an ethical duty for health
27 organizations. Additionally, the World Health Organization declared that palliative care is an
28 ethical duty of health professionals and, in 2012, the United Nations Office of the High
29 Commissioner for Human Rights recognized that the failure to provide palliative care and end of
30 life care to older persons is a human rights violation. Furthermore, in 2011, the World Medical
31 Association (WMA) adopted the Declaration on End-of-Life Medical Care which declared that
32 "The objective of palliative care is to achieve the best possible quality of life through appropriate
33 palliation of pain and other distressing physical symptoms, and attention to the social,
34 psychological and spiritual needs of the patient and is part of good medical care" [10]. Three years
35 later, the WMA further expanded their support of palliative care with the adoption of a resolution
36 which called for the integration of palliative care in global disease control and health system plans.
37 Additionally, major world religions also endorse palliative care [21].

38
39 Despite the continued support for palliative care within the AMA HOD and from medical
40 organizations across the globe, the *Code* remains silent on what constitutes the ethical provision of
41 palliative care. Providing guidance on the ethical practice of palliative care in the *Code* is important
42 because there is not one standard definition of palliative care and what it entails. Additionally,
43 palliative care is often misattributed as being connected to physician assisted suicide or euthanasia.
44 Misattribution and confusion about the scope of palliative care may be contributing to the
45 underutilization of this high quality, evidence based, medical intervention. As there is an
46 established ethical duty within the *Code* to provide palliative care and HOD policies which
47 encourage the provision of palliative care, it is imperative to offer clinicians guidance on what the
48 ethical delivery of high-quality palliative care entails. Additionally, it is imperative to distinguish
49 palliative care, which is an ethical duty, from other practices which either straddle the line of
50 ethical acceptability or are considered by the *Code* as unethical in the practice of medicine (e.g.,
51 knowingly and intentionally hastening death, physician assisted suicide, and euthanasia). Lastly,

1 given the rapid and vast evolution of palliative care as a medical discipline, it is important to
2 update the 1991 CEJA report's understanding of the scope and way in which palliative care is
3 ethically implemented during clinical practice.

4 5 *The Aim of Palliative Care is Not Hastening Death*

6
7 Providing palliative care is ethically distinguishable from physician assisted suicide and euthanasia,
8 both of which are intended to cause death. It is important, however, to recognize that treatments for
9 the relief of intractable pain/agitation/dyspnea may theoretically (and very rarely if the clinician is
10 well trained in symptom management) result in the unintended consequence of hastening death. To
11 the contrary, uncontrolled symptom distress, including moderate to severe pain, agitation,
12 depression, and dyspnea, are all associated with a higher risk of death [21-25]. The ethical concept
13 of "double effect" hinges on the intention of the medical intervention. It stipulates that an
14 intervention is ethically permissible if it is provided with the intention of relieving pain or treating
15 symptoms, even if the intervention has the foreseen but unintended side effect of hastening death,
16 provided that the benefits outweigh the burdens and the relief of symptoms or suffering is not
17 achieved by means of causing death [26]. Conversely, this same intervention would be deemed
18 unethical if the primary intention was to hasten death. Patients and/or their surrogate medical
19 decision makers should be provided informed consent which allows them to determine if the risk of
20 intentionally hastening death is worth the relief of pain and/or suffering.

21 22 *Palliative Care is Offered Concurrently with Curative Treatments*

23
24 The *Code* contains many ethical opinions permitting the withholding or withdrawing of medical
25 interventions for life-prolonging purposes. For example, patients with decision making capacity
26 have the ethical right to decline or stop any medical intervention, even if this decision will result in
27 their death ([Opinion 5.3](#)). Additionally, patients have the ethical right to refuse cardiopulmonary
28 resuscitation attempts through the execution of a Do Not Resuscitate Order ([Opinion 5.4](#)). In
29 addition to patients having the ethical right to determine if they want to start or continue an offered
30 medical treatment, physicians also have an ethical duty to not provide interventions that, "in their
31 best medical judgement, cannot reasonably be expected to yield the intended clinical benefit or
32 achieve agreed-on goals for care" ([Opinion 5.5](#)).

33
34 Although there is a well-established ethical basis for medical interventions to be withheld or
35 withdrawn from both the patient and physicians' perspective, there is also a well-established ethical
36 "duty to relieve pain and suffering" that is "central to the physician's role as healer and is an
37 obligation physicians have to their patients" ([Opinion 5.6](#)). Further, as noted above, symptom
38 distress is consistently associated with a higher risk of death, adding to the professional obligation
39 to ameliorate it. Additionally, physicians have an ethical duty to "respond to the needs of patients
40 at the end of life", and they "should not abandon a patient once it is determined that a cure is
41 impossible" ([Opinion 5.8](#)).

42
43 The provision of palliative care bridges these ethical obligations by providing physical and
44 emotional support to patients and their family/ care partners during the entire illness trajectory.
45 Palliative care is offered to patients concurrently with disease-directed treatments and interventions
46 and, therefore, it is not necessary to decide between continued treatment and palliative care
47 intervention because they are provided simultaneously. As the illness progresses and the patient's
48 medical goals transition from cure or prolonging life towards making the life that remains as
49 peaceful and functional as possible, hospice should be offered to the patient and their family.
50 Although life prolonging interventions (for the terminal condition) are not offered as a Medicare

1 Condition of Participation in hospice during the provision of comfort care, the patient and their
2 family are provided physical, emotional, spiritual, and practical support during the dying process.

3
4 CONCLUSION

5
6 Although our AMA adopted a CEJA report in 1991 which recommend “providing effective
7 palliative treatment . . .” a *Code* opinion speaking to what it means to practice ethical and effective
8 palliative care has never been adopted [7]. This is problematic because palliative care is an
9 essential part of a patient’s serious illness experience and provides beneficial outcomes in terms of
10 symptom distress, patient and family understanding of what to expect and how to prepare for it,
11 and reduction in use of Emergency Department and hospital admission for symptom crises. This is
12 further problematic because the term “palliative treatment” is referred to in both the *Code* and
13 numerous HOD policies; however, the ethical provision of this medical practice is neither
14 discussed nor defined in house policies or in the *Code*.

15
16 RECOMMENDATION

17
18 Given both the AMA Policy and CEJA’s historical support of addressing the palliative needs of
19 patients and the duty of clinicians to provide optimal palliative care to patients, it is recommended
20 that the *Code of Medical Ethics* be amended to include a new opinion on Palliative Care.

21
22 Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by
23 illness and injury and to respect their patients as whole persons. These duties require
24 physicians to assure the provision of effective palliative care whenever a patient is
25 experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative
26 care is sound medical treatment that includes the comprehensive management and coordination
27 of care for pain and other distressing symptoms including physical, psychological, intellectual,
28 social, spiritual, and existential distress from serious illness. Evaluation and treatment are
29 patient-centered but with an additional focus on the needs, values, beliefs, and culture of
30 patients and those who love and care for them in decision-making accordingly.

31
32 Palliative care is widely acknowledged to be appropriate for patients who are close to death,
33 but persons who have chronic, progressive, and/or eventually fatal illnesses often have
34 symptoms and experience suffering early in the disease course. The clinical ethical
35 responsibilities to address symptoms and suffering may therefore sometimes entail a need for
36 palliative care before the terminal phase of disease. Moreover, the duty to respect patients as
37 whole persons should lead physicians to encourage patients with chronic, progressive, and/or
38 eventually fatal conditions to identify surrogate medical decision makers, given the likelihood
39 of a loss of decisional capacity during medical treatment.

40
41 When caring for patients' physicians should:

- 42
43 (a) Integrate palliative care into treatment.
44
45 (b) Seek and/or provide palliative care, as necessary, for the management of symptoms and
46 suffering occasioned by any serious illness or condition, at any stage, and at any age
47 throughout the course of illness.
48
49 (c) Offer palliative care simultaneously with disease modifying interventions, including
50 attempts for cure or remission.

- 1 (d) Be aware of, and where needed, engage palliative care expertise in care.
2
3 Physician as a profession should:
4
5 (e) Advocate that palliative care be accessible for all patients, as necessary, for the
6 management of symptoms and suffering occasioned by any serious illness or condition, at
7 any stage, and at any age throughout the course of illness.
8
9
10 (New Policy)

Fiscal Note: Less than \$500

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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-24)
“Protecting Physicians Who Engage in Contracts to Deliver Health Care Services”
(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. Private equity firms’ incursion into health care raises several ethical concerns and warrants extreme 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 dilemmas and obligations 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 2-I-24

Subject: Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Presented by: Jeremy A. Lazarus, 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”, the Council on Ethical and
5 Judicial Affairs (CEJA) presented Report 02-A-23, and later a revised Report 03-A-24, which
6 offered recommendations on amending [Opinion 11.2.3](#), “Contracts to Deliver Health Care
7 Services.” The 2024 report was referred back to CEJA, with testimony expressing a desire that a
8 stronger stance be taken against private equity’s involvement in health care.

10 BACKGROUND

11
12 The past several decades have seen an increase in the corporatization, financialization, and
13 commercialization of health care [1,2]. Since 2018, more physicians now work as employees of
14 hospitals or health care systems rather than in private practice [3,4]. Our AMA reports that this
15 trend is continuing: “[e]mployed physicians were 50.2 percent of all patient care physicians in
16 2020, up from 47.4 percent in 2018 and 41.8 percent in 2012. In contrast, self-employed physicians
17 were 44 percent of all patient care physicians in 2020, down from 45.9 percent in 2018 and 53.2
18 percent in 2012” [4]. A major factor in these trends has been the incursion of private equity into
19 health care. It is estimated that private equity capital investment between 2000 and 2018 grew from
20 \$5 billion to \$100 billion [1]. Between 2016 and 2017 alone, the global value of private equity
21 deals in health care increased 17 percent, with health care deals comprising 18 percent of all
22 private equity deals in 2017 [5].

23
24 Private equity firms use capital from institutional investors to purchase private practices, typically
25 utilizing a leveraged buy-out model that finances the majority of the purchase through loans for
26 which the physician practice serves as security, with the goal of selling the investment within 3 to 7
27 years and yielding a return of 20-30 percent [1,5,6]. However, private equity investment broadly
28 encompasses many types of investors and strategies, including venture capital firms that primarily
29 invest in early-stage companies for a minority ownership, growth equity firms that tend to partner
30 with promising later-stage ventures, and traditional private equity firms that borrow money through
31 a leveraged buyout to take a controlling stake of mature companies [7].

32
33 When ownership shifts from physicians to private equity firms, the firms typically seek to invest
34 resources to expand market share, increase revenue, and decrease costs to make the practice more

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

9
10 Proponents of private equity investments in health care claim that private equity provides access to
11 capital infusions, which may facilitate practice innovation and aid in the adoption of new
12 technological infrastructure [6,8]. Proponents also advocate that private equity can bring “valuable
13 managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase
14 healthcare access by synergistically aligning profit incentives with high quality care provision”
15 [10].

16
17 Critics argue that private equity’s focus on generating large, short-term profits likely establishes an
18 emphasis on profitability over patient care, which creates dual loyalties for physicians working as
19 employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits
20 likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-
21 emphasis on profitable services, limits access to care for certain patient populations (such as
22 uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or
23 Medicare patients), and fundamentally limits physician control over the practice and clinical
24 decision making [5,8,10].

25
26 Despite strong opinions regarding private equity’s incursion into medicine, empirical research on
27 the effects of private equity investments in health care, and the impacts on patient outcomes, is
28 currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because
29 “[p]rivate equity firms aren’t required to publicly disclose acquisitions or sales, and the widespread
30 use of nondisclosure agreements further contributes to opacity about practice ownership and the
31 nature of transactions” [6]. More research is needed on the effects of private equity investment in
32 the health care sector, as little empirical evidence exists on how private equity impacts utilization,
33 spending, or patient outcomes. Of the empirical research that has been done, evidence on the
34 effects of private equity acquisition of health care entities on patient outcomes has been mixed
35 [10,13-15].

36
37 Regardless, there is widespread concern among physicians that private equity-controlled practices
38 result in worse patient outcomes. This is particularly worrisome as private equity firms are
39 emerging to be major employers of physicians. Currently, it is estimated that eight percent of all
40 private hospitals in the U.S. and 22 percent of all proprietary for-profit hospitals are owned by
41 private equity firms [11].

42 43 *Relevant Laws*

44
45 Fuse Brown and Hall write that despite the market consolidation that results from private equity
46 acquisitions within health care, these acquisitions generally go unreported and unreviewed since
47 they do not exceed the mandatory reporting threshold under the Hart-Scott-Rodino (HSR) Act and
48 that there are currently no legal guidelines for assessing the collective market effects of add-on
49 acquisitions. However, they do note:

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

9 To protect patients from harmful billing practices, the federal government has passed the No
 10 Surprises Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most
 11 states have similar laws, such as those barring fee-splitting and self-referral, and several states have
 12 passed laws regulating or restricting the use of gag clauses in physician contracts. The FTC has
 13 also recently proposed a rule banning noncompete clauses in all employment contracts [1].
 14

15 The federal Emergency Medical Treatment and Labor Act ensures that hospitals with an
 16 emergency department provide all patients access to emergency services regardless of their ability
 17 to pay. Similarly, federal law requires nonprofit hospitals, which account for 58 percent of
 18 community hospitals, provide some level of charity care as a condition for their tax-exempt status,
 19 which the Internal Revenue Service defines as “free or discounted health services provided to
 20 persons who meet the organization’s eligibility criteria for financial assistance and are unable to
 21 pay for all or a portion of the services” [16].
 22

23 *Relevant AMA Policy Provisions*

24
 25 Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and
 26 venture capital investment in health care, and its recommendations were adopted as Policy [H-](#)
 27 [160.891](#), “Corporate Investors.” This policy delineates 11 factors that physicians should consider
 28 before entering into partnership with corporate investors, including alignment of mission, vision,
 29 and goals; the degree to which corporate partners may require physicians to cede control over
 30 practice decision making; process for staff representation on the board of directors and medical
 31 leadership selection; and retaining medical authority in patient care and supervision of
 32 nonphysician practitioners.
 33

34 Our AMA further developed and published materials to assist physicians contemplating partnering
 35 with private equity and venture capital firms:
 36

- 37 • Venture Capital and Private Equity: How to Evaluate Contractual Agreements
- 38 • Model Checklist: Venture Capital and Private Equity Investments
- 39 • Snapshot: Venture Capital and Private Equity Investments

40
 41 Policy [H-310.901](#), “The Impact of Private Equity on Medical Training,” encourages GME training
 42 institutions and programs to “demonstrate transparency on mergers and closures, especially as it
 43 relates to private equity acquisition” and asserts that our AMA will “[s]upport publicly funded
 44 independent research on the impact that private equity has on graduate medical education.”
 45

46 *Relevant AMA Code Provisions*

47
 48 [Opinion 10.1.1](#), “Ethical Obligations of Medical Directors,” states that physicians in administrative
 49 positions must uphold their core professional obligations to patients. The opinion mandates that
 50 physicians in their role as medical directors should help develop guidelines and policies that are

1 fair and equitable, and that they should always “[p]ut patient interests over personal interests
2 (financial or other) created by the nonclinical role.”

3
4 [Opinion 11.2.1](#), “Professionalism in Health Care Systems,” acknowledges that “[p]ayment models
5 and financial incentives can create conflicts of interest among patients, health care organizations,
6 and physicians” and offers recommendations for physicians within leadership positions regarding
7 the ethical use of payment models that influence where and by whom care is delivered. Key
8 elements include the need for transparency, fairness, a primary commitment to patient care, and
9 avoiding overreliance on financial incentives that may undermine physician professionalism.

10
11 [Opinion 11.2.2](#), “Conflicts of Interest in Patient Care,” clearly states: “[t]he primary objective of
12 the medical profession is to render service to humanity; reward or financial gain is a subordinate
13 consideration. [...] When the economic interests of the hospital, health care organization, or other
14 entity are in conflict with patient welfare, patient welfare takes priority.”

15
16 [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” stipulates that physicians’
17 fundamental ethical obligation to patient welfare requires physicians to carefully consider any
18 contract to deliver health care services they may enter into to ensure they do not create untenable
19 conflicts of interest. The opinion states that physicians should negotiate or remove “any terms that
20 unduly compromise physicians’ ability to uphold ethical standards.” However, it should be
21 acknowledged that physicians have little leverage in changing entire payment structures or
22 reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians
23 in private practice often feel that they have little leverage in negotiating the sale of their practice;
24 they simply receive an offer and are told they can take it or leave it.

25
26 [Opinion 11.2.3.1](#), “Restrictive Covenants,” states: “[c]ovenants-not-to-compete restrict
27 competition, can disrupt patient care, and may limit access to care” and that physicians should not
28 enter into covenants that “[u]nreasonably restrict the right of a physician to practice medicine for a
29 specified period of time or in a specified geographic area on termination of a contractual
30 relationship”. However, many hospitals and hospital systems today now routinely include
31 noncompete clauses as part of their physician contracts. These clauses put physicians at risk of
32 violation of professional obligations and their widespread use has the potential to undermine the
33 integrity of the profession as a whole. While the FTC issued a rule in April 2024 banning most
34 noncompete agreements, a Texas District Judge issued a preliminary injunction on July 3, 2024,
35 halting the enforcement of the ban, with a final order on the merits due by August 30, 2024.

36 37 ETHICAL ANALYSIS

38
39 The increasing corporatization and financialization of health care have generated legitimate
40 concerns over ethical dilemmas they raise regarding a focus on profits at the expense of patient
41 care. Because it is unethical to place profit motives above commitments to patient care and well-
42 being, private equity firms’ commitment to ensuring short-term, high returns on their investments
43 creates a potential ethical dilemma when investing in health care. This report examines whether
44 private equity investments in health care may be ethical, as well as how physicians may ethically
45 navigate private equity buyouts and employment in today’s rapidly evolving financial health care
46 landscape.

47
48 A major concern of physicians regarding private equity investments in health care is the potential
49 loss of autonomy, which physicians worry could translate into practice policies designed for
50 profitability and that limit physicians’ decision-making and their ability to care for patients [9].
51 Loss of autonomy is also associated with increased physician burnout [12]. There are also valid

1 concerns that private equity ownership leads to increased patient volumes and more expensive and
2 potentially unnecessary procedures [9]. The debate over private equity’s incursion into health care
3 often regards private equity acquisitions through a lens of exceptionalism—either negatively or
4 positively. However, although private equity-owned health care entities are different in their
5 ownership structure and oversight compared to other traditional health care investors, private
6 equity-acquired health care entities may not be substantively different from other for profit and
7 non-profit health care entities in terms of their stated goals of both solvency and patient care. Zhu
8 and Polsky argue that private equity is not inherently unethical and that there are likely good and
9 bad actors as is the case in many sectors [6]. They add: “physicians should be aware that private
10 equity’s growth is emblematic of broader disruptions in the physician-practice ecosystem and is a
11 symptom of medicine’s transformation into a corporate enterprise” [6].
12

13 The corporatization of medicine comes with ethical and professional risks that are perhaps best
14 exemplified by private equity but are not unique to private equity alone. One only needs to turn to
15 the systemic failure of nonprofit hospitals to provide adequate charity care or how for-profit
16 hospitals often reduce access to care (particularly for Medicaid recipients) to see examples of how
17 the corporatization and financialization of medicine has increasingly come to treat health care as a
18 mere commodity [17,18]. This is despite the fact that health care is inherently different from
19 normal market goods because the demand for health care is substantially inelastic and nonfungible,
20 and medical knowledge is a social good collectively produced by the work of generations of
21 physicians, researchers, and patients. The real problem with private equity’s involvement in health
22 care is that it blatantly reveals that as a society, we have increasingly moved towards treating health
23 care as a commodity when as a profession, we know this should not be the case.
24

25 While business ethics and medical ethics are not inherently antithetical, differences do clearly exist
26 [19]. Many physicians are thus justly concerned about any removal of professional control that may
27 accompany the increasing commercialization of the physician’s role. Veatch points out that
28 paradoxically, despite being open to the profit motive in the practice of medicine, the profession as
29 a whole has shown strong resistance to the commercialization of medical practice. For Veatch, the
30 crux of the issue is whether people perceive health care as a fundamental right or a commodity like
31 any other, adding that the notion of health care as a right jeopardizes any profit motive in health
32 care including traditional private practitioner fee-for-service models [19].
33

34 Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human
35 good that society has an obligation to provide in some measure to all citizens [20]. Pellegrino
36 argues that health care is substantively different from traditional market goods—it is not fungible,
37 cannot be proprietary because medical knowledge is possible only due to collective achievements,
38 is realized in part through the patient’s own body, and requires an intensely personal relationship—
39 and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine
40 turns any interaction between the patient and physician into a commercial transaction subject to the
41 laws and ethics of business rather than to medical and professional ethics. “In this view,”
42 Pellegrino writes, “inequities are unfortunate but not unjust [...]. In this view of health care,
43 physicians and patients become commodities too” [20].
44

45 Rather than claiming that health care is a fundamental right, Pellegrino takes a position of
46 distributive justice to argue that health care is a collective good. Because a good society is one in
47 which each citizen is enabled to flourish, and good health is a condition of human flourishing,
48 society has a moral responsibility to provide health care to all citizens. In this light, health care is
49 both an individual and a social good. Pellegrino also refers to this view as one of “beneficent
50 justice” and explains, “[t]reating health care as a common good implies a notion of solidarity of
51 humanity, i.e., the linkage of humans to each other as social beings” [20]. Pellegrino concludes:

1 Understanding health care to be a commodity takes one down one arm of a bifurcating
2 pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking
3 health care as a human good takes us down a divergent pathway to the resolution of
4 injustice through a moral ordering of societal and individual priorities [20].
5

6 Whether health care is understood as a commodity or a human good is of course not always so
7 clear in policy and in practice. What is evident, however, is that as health care has become
8 increasingly commodified, the ethical risks to patients and physicians are being realized as
9 physicians find themselves increasingly working as employees and worrying about the impact that
10 commercial enterprises—such as private equity investments—may be having on patients.
11

12 Private equity represents the latest and most extreme form of health care commercialization that
13 has escalated over the past few decades. This is the very reason why private equity firms became
14 interested in health care in the first place—they recognized that health care as a market was already
15 ripe for investment and future profitability. Private equity firms use the same investment models in
16 health care that they do in other industries—invest in fragmented markets, acquire the most
17 promising targets as a platform, expand through add-on acquisitions, and exit the market once a
18 significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each
19 individual acquisition is typically too small to require review by anti-trust regulators at the Federal
20 Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers
21 and acquisitions in the health care sector [9].
22

23 Fuse Brown and Hall explain, “[private equity] functions as a divining rod for finding market
24 failures—where PE has penetrated, there is likely a profit motive ripe for exploitation” [1]. They
25 continue that private equity investments pose three primary risks:
26

27 First, PE investment spurs health care consolidation, which increases prices and potentially
28 reduces quality and access. Second, the pressure from PE investors to increase revenue can
29 lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding,
30 harming patients through unnecessary care, excessive bills, and increasing overall health
31 spending. Third, physicians acquired by PE companies may be subject to onerous
32 employment terms and lose autonomy over clinical decisions [1].
33

34 While the profit motive of private equity firms may drive them to take part in less than scrupulous
35 practices, such as private equity’s exploitation of out-of-network surprise billing, there is also
36 potential for private equity to play a more positive role in transforming health care practices [1,21].
37 Powers et al write:
38

39 Ultimately, private equity—a financing mechanism—is not inherently good or bad.
40 Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-
41 service construct, this is intrinsically problematic. But value-based payment models can
42 serve as an important guardrail, helping to ensure that financial return to private equity
43 investors are appropriately aligned with system goals of access, quality, equity, and
44 affordability [21].
45

46 Private equity firms could help accelerate changes in health care payment and delivery towards
47 value-based models. With such models, where financial performance is tied to quality and value,
48 private equity may be incentivized to invest in changes that support better health and lower costs
49 [21].

1 While more research is needed on the impacts of private equity investments in health care, private
2 equity firms' involvement in health care does not appear to be exceptional within the current
3 corporate transformation of the profession and thus is inherently no more or less ethical than this
4 current trend that has penetrated health care and the practice of medicine far beyond interactions
5 with private equity. As Fuse Brown and Hall point out, "PE investment in health care is just the
6 latest manifestation of the long trend of increasing commercialization of medicine. And so long as
7 the U.S. treats health care as a market commodity, profit-seeking will persist" [1]. Any financing
8 model of health care that ignores patient care or puts profits over patient care should be considered
9 unethical by physicians and the public.

10
11 Concerns over private equity's incursion into health care are clearly warranted. However, the
12 financial and investment landscape of health care continues to evolve, and while private equity may
13 be the latest trend it will not be the last version that emerges within the health care marketplace.
14 Health care spending in the US continues to rise each year, with health spending increasing by
15 4.1percent in 2022 for a total of \$4.5 trillion and accounting for roughly 17 percent of total gross
16 domestic product [22]. With so much money involved in health care, it is bound to draw in
17 investors; the involvement of investors from outside of health care, who may treat it as merely a
18 market commodity and do not share physicians' overriding commitment to patient care and well-
19 being, should be concerning. Such involvement by outside investors is likely to further transform
20 health care, driving consolidation, commercialization, and de-professionalization.

21
22 In a practical approach to the current financial health care landscape, Ikrum et al offer some
23 realistic recommendations for partnering with private equity in health care:

24
25 While PE involvement in health care delivery invokes inherent concerns, it has provided
26 much-needed capital for many primary care practices to mitigate the effects of the
27 pandemic and to potentially undertake care delivery innovations such as population health
28 management under value-based payment models. To make partnerships with private
29 investors work, providers need to select the right investors, establish strategies upfront to
30 address misaligned objectives, and define a successful partnership by setting goals for and
31 transparently reporting on indicators that reflect both financial and clinical performance.
32 Safeguards and regulations on sales may also protect patients and providers [7].

33
34 While private equity's overriding profit motive may be unethical in many instances, the reality is
35 that private equity is already a large player in health care and physicians urgently need guidance on
36 how to interact with private equity firms and private equity-owned health care entities. Keeping
37 within its purview, the *Code* should offer guidance to physicians and to the practice of medicine on
38 how to best interact with private equity and other outside forces that increasingly impact health
39 care today. To support physicians as private equity continues to increase its market share of health
40 care entities, practical guidance is needed related to both the sale of physician-owned practices to
41 private equity as well as to those seeking employment by private equity-owned health care entities
42 to help physicians navigate today's evolving financial health care landscape.

43 44 CONCLUSION

45
46 The ethical concerns raised by private equity investments in health care are not unique but instead
47 represent ethical dilemmas that exist due to the very nature of treating health care as a commodity.
48 Any decision to pursue financial incentives over and above patient care is unethical, and
49 physicians' concerns regarding private equity's focus on short-term profits at the expense of
50 patients' and their own well-being are justly warranted. Due to such concerns, physicians should

1 strongly consider whether they can sell their practice to private equity investors while also
2 upholding their ethical and professional obligations to patients and to the profession as a whole.

3
4 It is therefore crucial that policy guidelines be developed to ensure that private equity-acquired
5 hospitals, hospital systems, and physician practices function in an ethical manner that prioritizes
6 patients and patient care over profits. Policies that require greater transparency and disclosure of
7 data on private equity ownership, greater state regulatory control over private equity acquisitions,
8 closing payment and billing loopholes, rules requiring an independent clinical director on the
9 Board of private equity firms engaged in health care, and means for physicians to help set goals
10 and measure outcomes to ensure the alignment of corporate and clinical values should be
11 considered [7]. The growth of private equity investment within the health care marketplace is
12 clearly concerning and is an urgent issue that needs greater regulatory oversight. Beyond
13 established ethical and professional norms, new regulations must be developed to prevent private
14 equity from negatively impacting patient care and the medical profession [6].

15
16 Though the current literature is conflicting, there are valid concerns that private equity investment
17 in health care might negatively impact patient outcomes. Significantly, since serious potential risks
18 and conflicts of interest do exist, it is essential for physicians considering entering into partnership
19 with private equity firms to first reflect on their ethical and professional obligations. If they do
20 decide to proceed, however, physicians have a duty to evaluate their contracts and require that the
21 agreements are consistent with the norms of medical ethics. Likewise, physicians considering
22 entering into a contractual relation as an employee—whether with a private equity-owned hospital
23 or otherwise—should ensure that their contract does not place them in an untenable conflict of
24 interest or compromise their ability to fulfill their ethical and professional obligations to patients
25 [8]. While we must acknowledge that physicians often have little power in contract negotiations,
26 their ethical obligation remains nonetheless to try to negotiate when contractual agreements are
27 likely to lead to ethical dilemmas.

28
29 The [Preamble](#) to the *Code* stipulates that “[o]pinions of the AMA Council on Ethical and Judicial
30 Affairs lay out the ethical responsibilities of physicians as members of the profession of medicine.”
31 Although some areas of concern therefore extend beyond what the *Code* may speak to, CEJA is
32 currently studying the ethical obligations of health care entities that interact with physicians and is
33 considering entering a report in the near future regarding the potential need for a new opinion to
34 address additional stakeholders involved in our evolving health care landscape.

35
36 It is the conclusion of the Council on Ethical and Judicial Affairs that increasing investment by
37 private equity firms in health care raises ethical concerns regarding dual loyalties of physicians and
38 competing interests between profits and patients. To respond to these issues, CEJA recommends
39 amending [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” to more clearly address
40 concerns raised by entering into partnerships with private equity firms and the ethical risks that
41 may arise for both physicians seeking capital to support their private practice as well as physicians
42 entering into employment contracts with private equity-owned health care entities.

43 44 RECOMMENDATION

45
46 In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that
47 [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” be amended by addition and deletion
48 as follows and the remainder of this report be filed:

1 While profitmaking is not inherently unethical, no part of the health care system that supports
 2 or delivers patient care should place profits over such care. Physicians have a fundamental
 3 ethical obligation to put the welfare of patients ahead of other considerations, including
 4 personal financial interests. This obligation requires ~~them to~~ that before entering into contracts
 5 to deliver health care services, physicians consider carefully the proposed contract to assure
 6 themselves that its terms and conditions of contracts to deliver health care services before
 7 ~~entering into such contracts to ensure that those contracts do not create untenable conflicts of~~
 8 interest or compromise their ability to fulfill their ethical and professional obligations to
 9 patients.

10
 11 Ongoing evolution in the health care system continues to bring changes to medicine, including
 12 changes in reimbursement mechanisms, models for health care delivery, restrictions on referral
 13 and use of services, clinical practice guidelines, and limitations on benefits packages. While
 14 these changes are intended to enhance quality, efficiency, and safety in health care, they can
 15 also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent~~
 16 ~~and fidelity to patients~~ and can impede physicians' freedom to exercise independent
 17 professional judgment and tailor care to meet the needs of individual patients.

18
 19 As physicians seek capital to support their practices or enter into various differently structured
 20 contracts to deliver health care services—with group practices, hospitals, health plans,
 21 investment firms, or other entities—they should be mindful that while ~~many~~ some
 22 arrangements have the potential to promote desired improvements in care, some other
 23 ~~arrangements also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere
 24 with physician autonomy.

25
 26 When contracting with entities, or having a representative do so on their behalf, to provide
 27 health care services, physicians should:

- 28
 29 (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and
 30 ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the
 31 arrangement:
 32
 33 (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms,
 34 financial or performance incentives, restrictions on care, or other mechanisms intended
 35 to influence physicians' treatment recommendations or direct what care patients
 36 receive, in keeping with ethics guidance;
 37
 38 (ii) does not compromise the physician's own financial well-being or ability to provide
 39 high-quality care through unrealistic expectations regarding utilization of services or
 40 terms that expose the physician to excessive financial risk;
 41
 42 (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;
 43
 44 (iv) includes a mechanism to address grievances and supports advocacy on behalf of
 45 individual patients;
 46
 47 (v) is transparent and permits disclosure to patients;
 48
 49 (vi) enables physicians to have significant influence on, or preferably outright control of,
 50 decisions that impact practice staffing.

- 1 (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability
2 to uphold ethical or professional standards.
3

4 When entering into contracts as employees, preferably with the advice of legal and ethics
5 counsel, physicians should:
6

- 7 (c) Advocate for contract provisions to specifically address and uphold physician ethics and
8 professionalism.
9

- 10 (d) Advocate that contract provisions affecting practice align with the professional and ethical
11 obligations of physicians and negotiate to ensure that alignment.
12

- 13 (e) Advocate that contracts do not require the physician to practice beyond their professional
14 capacity and provide contractual avenues for addressing concerns related to good practice,
15 including burnout or related issues.
16

17
18 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-24)

Introduced by: Women Physicians Section

Subject: Addressing Gender-Based Pricing Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, up to 80% of consumer-based products are segmented by gender, with female
2 targeted products costing up to 7% more than male targeted products¹; and
3
4 Whereas, a U.S. Government Accountability Office investigation on gender-based price
5 differences found that deodorants, shaving creams, and disposable razor blades targeted
6 towards female consumers had higher prices compared to similar products advertised toward
7 male consumers²⁻⁴; and
8
9 Whereas, a JAMA Dermatology study found that Minoxidil prescriptions were priced significantly
10 more per volume for female patients compared to male patients⁵; and
11
12 Whereas, facial moisturizers marketed towards female consumers are on average \$3.09 more
13 per ounce than moisturizers marketed towards male consumers, despite no significant
14 differences in the products' targeted skin-concerns⁶; and
15
16 Whereas, women spend more than 15 billion dollars annually more than men on healthcare
17 costs, but they also pay 18% more on average for out-of-pocket medical expenses than men
18 despite having similar insurance coverage⁷; and
19
20 Whereas, older women are disproportionately affected by gaps in coverage for long-term-care
21 services and higher out-of-pocket expenses⁸; and
22
23 Whereas, menstrual products are a necessity, and past efforts have made these products tax-
24 exempt in 24 states, but many women in non-tax-exempt states pay taxes ranging from 4-7% on
25 menstrual products⁹⁻¹¹; and
26
27 Whereas, lack of affordable access to menstrual products increases exposure to health risks
28 such as urinary tract infection, candidiasis, and mental health disorders such as depression and
29 anxiety¹²⁻¹⁴; and
30
31 Whereas, the compounding effects of increasing wage gap, gender pricing disparities, and sole
32 household income earners result in negative overall effects on health and quality of life
33 particularly for women¹⁵⁻¹⁸; and
34
35 Whereas, state and local jurisdictions have passed laws to prohibit gender-based price
36 discrimination, and the Pink Tax Repeal Act has been introduced in Congress^{4, 14, 19}; therefore
37 be it

38 RESOLVED, that our American Medical Association support federal and state efforts to
39 minimize gender-based pricing disparities in healthcare services and products. (New HOD
40 Policy)

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

Date Submitted: 9/19/2024

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RELEVANT AMA POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974

Our AMA encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities: (1) will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; and (2) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. [Res. 218, A-18; Modified: Res. 209, I-21]

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products. [Res. 215, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-24)

Introduced by: Women Physician Section

Subject: Anti-Doxxing Data Privacy Protection

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the onus of advocacy burden is often placed on minorities themselves, such as in the
2 context of abortion and gender-affirming healthcare advocacy, and thus harassment and
3 doxxing over these issues also disproportionately affect women and minorities^{2,3}; and
4

5 Whereas, doxxing refers to unconsented publishing of private information (such as name, home
6 address, phone number, email address, school, and workplace) in public forums such as social
7 media and the Internet to facilitate harassment or intimidation of victims²; and
8

9 Whereas, in June 2024 a doxxing list of individuals (name and city of residence) from Arkansas
10 involved in a grassroots abortion rights ballot petition was circulated on the Internet by the
11 Family Council, a conservative group that opposes the amendment. This doxxing resulted in
12 death threats, harassment, and intimidation towards activists for medically underserved
13 populations^{4,5,6,7}; and
14

15 Whereas, a systematic review of information posted on an anti-abortion website indicated
16 extensive personal information for 64 abortion providers in 24 states published on the website in
17 an accessible and searchable format, violating personal privacy and representing a pattern of
18 efforts to intimidate, threaten, and vilify providers⁸; and
19

20 Whereas, from 2021 to 2022, death threats and other threats of violence increased by 20%,
21 including threats communicated on the Internet, threatening calls and mail to abortion clinics,
22 and stalking incidents doubled. U.S. abortion rights campaigner Alison Dreith reported moving
23 houses four times in the last five years due to fears to personal safety from threatening letters to
24 her address^{9,10,11,12}; and
25

26 Whereas, data broker companies profit off of selling information due to lack of industry
27 regulation, and attempts to remove personal information from the internet are costly
28 expenses^{10,13}; and
29

30 Whereas, the politicization of gender-affirming care has also resulted in targeted harassment
31 (threats of violence, doxxing, bomb threats) of adolescent gender-affirming care providers, with
32 70% sharing that either they, their practice, or their institution received threats specific to gender
33 affirming care delivery and several receiving death threats¹⁴; and
34

35 Whereas, providers reported this harassment led to concerns about safety,
36 emotional/psychological toll, limited access to care, and decreased ability to advocate for their
37 patients due to fear for the safety of themselves, their colleagues, and family¹⁴; and

1 Whereas, providers expressed that large institutions, such as hospitals and professional
2 organizations should show more public-facing support for issues that resulted in doxxing to
3 support their providers in advocacy¹⁴; and
4

5 Whereas, a psychological study of how doxxing influences hiring-related decisions revealed that
6 doxxing influenced suspicion of job applicants and expected retaliation from individuals outside
7 the organization, and thus may induce employment bias and discrimination¹⁵; and
8

9 Whereas, in a survey of pediatric endocrinologists providing gender-affirming care in states
10 where legislation banning gender-affirming care had been proposed or passed, respondents
11 experienced threats to personal safety, concerns about their career (recommendation for
12 promotion, job security, etc.), and institutional concerns about engagement with media¹⁶; and
13

14 Whereas, in 2020, 9-12% of public health officials reported receiving either individual or family
15 threats, with their residential addresses, phone numbers, and emails doxxed through the
16 Internet¹⁷; and
17

18 Whereas, many officials feared loss of their jobs or putting themselves at further risk, leaving
19 them silent, isolated, and pressured to comply with public or political opinions rather than
20 focusing on what is best for community health¹⁷; and
21

22 Whereas, H.R.2701 Online Privacy Act of 2023, which establishes online privacy rights for
23 personal information, allowing individuals to access, correct, and request the deletion of their
24 information, was introduced in April 2023 but has not yet passed the House^{18,19,20}; and
25

26 Whereas, S.2121 DELETE Act was proposed to establish a centralized system to allow
27 individuals to request the simultaneous deletion of their personal information across all data
28 brokers²¹; and
29

30 Whereas, current AMA policy does not address the issue of doxxing and personal data privacy
31 outside of the context of healthcare data, and bills listed above addressing the underlying data
32 privacy rights issues have yet to be passed by Congress; therefore be it
33

34 RESOLVED, that our American Medical Association support physicians and healthcare
35 providers that provide reproductive and gender-affirming care who experience doxxing, support
36 nondiscrimination and privacy protection for employees, and availability of resources on doxxing
37 (New HOD Policy); and be it further
38

39 RESOLVED, that our AMA work with partners to support data privacy and anti-doxxing laws to
40 prevent harassment, threats, and non-consensual publishing of information for physicians who
41 provide reproductive and gender-affirming care (Directive to Take Action); and be it further
42

43 RESOLVED, that our AMA encourage institutions, employers, and state medical societies to
44 provide legal resources and support for physicians who provide reproductive and gender-
45 affirming care who are affected by doxing (New HOD Policy); and be it further
46

47 RESOLVED, that our AMA encourage institutions, employers, and medical societies to provide
48 training and education on the issue of doxxing. (New HOD Policy)

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

Received: 9/19/2024

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RELEVANT AMA POLICY

Supporting Improvements to Patient Data Privacy D-315.968

1. Our AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data.
2. Our AMA will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other healthcare providers who are providing or receiving healthcare that may be criminalized in a given jurisdiction [Res. 227, A-22; Modified: Res. 230, I-22; Reaffirmation: A-23; Reaffirmed: CMS Rep. 07, A-24]

Anonymous Cyberspace Evaluations of Physicians D-478.980

Our AMA: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws.

[BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14; Consolidated with D-445.997: CCB/CLRPD Rep. 01, A-24]

National Provider Identification D-406.998

Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients.

[Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: BOT Rep. 09, A-24]

Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers. [Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-24)

Introduced by: Senior Physicians Section
Subject: On the Ethics of Human Lifespan Prolongation
Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, modern medicine, particularly through advancements in public health, has
2 progressively improved the human life expectancy from 45 to 75 years over the last century,
3 with an apparent biologic limit to the human lifespan of around 120 years^{1,2,3}; and
4
5 Whereas, the recent scientific advancements probing the aging process have raised the real
6 possibility of significantly lengthening the human lifespan^{4,5,6}; and
7
8 Whereas, this potential for prolonging the human lifespan raises a number of ethical issues
9 including equitable access, distributive justice, allocation of limited resources, and potentiating
10 healthcare disparities; and
11
12 Whereas, our American Medical Association has been traditionally a leader in medical ethics;
13 therefore be it
14
15 RESOLVED, that our American Medical Association undertake an evaluation of the ethics of
16 extension of the human lifespan, currently considered to be 120 years, with the goal of providing
17 guidance and/or guidelines for clinical practice, research and potential regulatory challenges.
18 (Directive to Take Action)

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

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RELEVANT AMA POLICY

D-85.993 Increased Death Rate and Decreased Life Expectancy in the United States

Our AMA: (1) will raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly; (2) will call on the legislative and executive branches of the Federal Government to fund and carry out investigations into the causes of these very unusual decreases in life expectancy and increases in death rates in order to design multi-

disciplinary interventions to reverse these troubling changes; and (3) encourages state and local medical societies to raise awareness of the new problems of decreasing life expectancy and increasing population death rates as indicators of major public health problems and advocate for local investigation of the causes and remedies for these disturbing problems.

[Citation: Res. 913, I-17]

H-25.998 Policy Recommendations in the Field of Aging

1. It is the policy of our American Medical Association that:
 - a. Older individuals should not be isolated.
 - b. A health maintenance program is necessary for every individual.
 - c. More persons interested in working with the older people in medical and other professional fields are needed.
 - d. More adequate nursing home facilities are an urgent health need for some older people in many communities.
 - e. Further development of service and facilities is required.
 - f. Extension of research on both medical and socioeconomic aspects of aging is vital.
 - g. Local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually.
 - h. Local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.
2. Our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states.

[Citation: CMS Rep. A, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CMS Rep.01, A-18; Appended: BOT Rep.11, I-21]

AMERICAN MEDICAL ASSOCIATION LGBTQ+ SECTION ASSEMBLY

Resolution: 004
(I-24)

Introduced by: LGBTQ Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Electronic Health Record (EHR) systems play a vital role in helping physicians track patient
2 demographics, clinical notes, diagnoses, and test results¹; and
3

4 Whereas, EHR systems reflect an assumption that everyone is cisgender, and many EHRs do not
5 provide sufficient flexibility or inclusivity for transgender and gender diverse (TGD) patients who do
6 not fit into the traditional binary of sex and gender²⁻⁴; and
7

8 Whereas, sex assigned at birth may inadequately describe current clinical sex for transgender
9 patients whose gender-affirming care alters secondary sex characteristics, hormone levels, or
10 genitals⁴; and
11

12 Whereas, multiple studies have demonstrated that the changes in chemistry and hematology
13 parameters from masculinizing and feminizing hormone therapies overall show good correlation
14 with cisgender male and female reference values^{5,6}; and
15

16 Whereas, the legal sex found on identity documents should not be used as a proxy for current sex
17 because it can be clinically misleading in many circumstances⁷; and
18

19 Whereas, both sex assigned at birth and current anatomy are needed to inform clinical
20 decisions, while legal sex may be required for billing and insurance purposes^{8,9}; and
21

22 Whereas, due to a variety of financial and institutional barriers, many TGD people may not be able
23 to formally change their legal name to reflect their chosen name; thus, their chosen name may not
24 appear on insurance and medical documentation¹⁰; and
25

26 Whereas, in TGD patient chart notes, the correct pronouns are used less than 40% of the time,
27 assigned sex at birth is recorded accurately less than 54% of the time and only 46% of TGD
28 patients were recorded with the proper ICD codes⁸; and
29

30 Whereas, gender identity data includes chosen name, pronouns, current gender identity, and sex
31 listed on original birth certificate¹¹; and
32

33 Whereas, the term "sexual preference" suggests that an individual's sexual orientation is a choice¹²⁻
34 ¹⁴; and
35

36 Whereas, the term "preferred name" and "preferred pronouns" imply optional use by providers as
37 opposed to the term "chosen name" which removes the implication of elective use¹²⁻¹⁴; and

1 Whereas, the term “preferred name” is a broad term which can be applied to any patient (i.e. Sue vs
2 Susan) and is not specific to the “chosen name” associated with some gender-diverse individuals
3 leading to the patient’s chosen name being documented in quotes or parentheses alongside their
4 legal deadname (i.e. Mark “Mary” Moore)¹⁵; and
5

6 Whereas, in most EMR a space for documenting “preferred name” exists alongside documenting
7 “legal name”, no such separate space exists to document a patient’s chosen name in a way that
8 minimizes appearance of legal names inconsistent with chosen name in documents presented to the
9 patient¹⁵; and
10

11 Whereas, the Office of the National Coordinator for Health Information Technology’s (ONC) sets
12 “preferred name” as standard and the AMA advocates for “preferred name” in communications with
13 ONC as opposed to chosen name¹⁶; and
14

15 Whereas, 40% of TGD people attempt suicide within their lifetime, with young people being most
16 likely to do so, and TGD youth who addressed by their chosen name experience lower rates of
17 depression, suicidal ideation, and suicidal behavior^{11,17}; and
18

19 Whereas, misgendering is when a person is addressed or described with pronouns that do not
20 reflect their gender identity¹¹, and is associated with experiences of depression, stress, and
21 stigma^{18,19}; and
22

23 Whereas, deadnaming is a form of misgendering that often occurs in healthcare settings in which a
24 transgender person is inadvertently addressed by their birth name which they no longer use, often
25 triggering gender dysphoria²⁰; and
26

27 Whereas, storing gender identity data in inconsistent locations across EHR platforms and
28 institutions adds further confusion to what is already a challenging topic for healthcare workers to
29 understand²¹; and
30

31 Whereas, twenty-three percent of TGD people have avoided necessary medical care due to fear
32 of being disrespected or mistreated, with misnaming and misgendering cited as common reasons
33 for doing so¹⁰; and
34

35 Whereas, automated cancer screening reminders for TGD patients may cause discomfort and
36 increased mistrust in medical professionals when the screening reminders are linked to sex
37 assigned at birth instead of the patient’s present organs; this can be prevented by organ
38 inventories, which list the patient’s present organs, and are recommended by the World
39 Professional Association for Transgender Healthcare^{2,8,22-24}; and
40

41 Whereas, many TGD people undergo medical and surgical gender-affirming interventions
42 including hormone replacement therapy, masculinizing chest surgery, breast augmentation,
43 hysterectomy, and genital surgeries, which may lead to an organ inventory that does not align
44 with the binary view of sex and gender upon which EHRs are structured²⁵; and
45

46 Whereas, patient sex as recorded in EHRs is used to generate health screenings, medication
47 dosages, and laboratory test ranges by taking into account assumed hormonal history and
48 anatomy typical for the specified sex²⁶; and
49

50 Whereas, TGD people with a uterus have a 37% lower odds of being up to date on their Pap
51 testing compared with cisgender people²⁷⁻³⁰; and

1 Whereas, incorrect application of sex-based risk stratification tools for bone health³¹ and
2 cardiovascular disease³², predicting hypoxemia in anesthetized patients during surgery⁴, and
3 estimated glomerular filtration rate³³ further compound poor TGD health outcomes¹⁰; and
4

5 Whereas, over half of healthcare professionals reported their EHRs have one field for both sexual
6 orientation and gender identity rather than separate fields for each, only 27% had the ability to
7 record patient pronouns, and 55% had the ability to record chosen name²¹; and when EHRs have
8 inclusive options, these features are often hidden behind a paywall or only available through
9 opting in to turn the features on³⁴; and
10

11 Whereas, only 10-20% of customers utilize trans-inclusive options in EHRs that have them, and
12 only a quarter of all patients have their gender identity listed in the EHR^{9,35}; and
13

14 Whereas, our AMA policy D-478.995 urges EHR vendors to adopt social determinants of health
15 templates without adding further cost to medical providers; and
16

17 Whereas, our AMA policy H-315.967 advocates for the inclusion of gender identity-related
18 demographics in medical documentation and incorporation of recommended best practices into
19 electronic health records; however, the suggestions for what to include leave an incomplete picture
20 of transgender patients' medical history, leading to unhelpful ambiguity of advocacy efforts;
21 therefore be it
22

23 RESOLVED, that our American Medical Association amend policy H-315.967 "Inclusive Gender,
24 Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to
25 read as follows:
26

27 **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on**
28 **Medical Documentation, H315.967**

29 Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological~~
30 ~~sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex
31 on identification documents, sexual orientation, ~~preferred~~-gender pronoun(s),
32 ~~preferred~~-chosen name, and clinically relevant, sex specific anatomy in
33 medical documentation, and related forms, including in electronic health
34 records, in a culturally-sensitive and voluntary manner, with efforts to improve
35 visibility and awareness of transgender and gender diverse patients' chosen
36 name and pronouns in all relevant EHR screens and to de-emphasize or
37 conceal legal name except when required for insurance and billing purposes;
38 (2) Will advocate for the inclusion of an organ inventory encompassing medical
39 transition history and a list of current present organs in EHRs, with efforts to
40 link organ-specific examinations and cancer screenings to the current organ
41 inventory rather than sex or gender identity; ~~(23)~~ Will advocate for collection
42 of patient data in medical documentation and in medical research studies,
43 according to current best practices, that is inclusive of sexual orientation,
44 gender identity, and other sexual and gender minority traits for the purposes
45 of research into patient and population health; ~~(34)~~ Will research the problems
46 related to the handling of sex and gender within health information technology
47 (HIT) products and how to best work with vendors so their HIT products treat
48 patients equally and appropriately, regardless of sexual or gender identity;
49 ~~(45)~~ Will investigate the use of personal health records to reduce physician
50 burden in maintaining accurate patient information instead of having to query
51 each patient regarding sexual orientation and gender identity at each
52 encounter; and ~~(56)~~ Will advocate for the incorporation of recommended best
53 practices into electronic health records and other HIT products at no additional

1 cost to physicians automatically. (7) Will advocate for patient informed consent
2 regarding how gender identity and related data will be used with the ability to
3 opt out of recording aforementioned data without compromising patient care;
4 (Modify Current HOD Policy); and be it further
5

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

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

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RELEVANT AMA POLICY

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize

hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. 9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974

Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

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

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician

Affirming the Medical Spectrum of Gender H-65.962

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
- (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
- (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
- (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
- (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
- (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
- (9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-24)

Introduced by: American Society for Reproductive Medicine

Subject: Updating the American Medical Association Definition of Infertility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the World Health Organization defines infertility as “a disease of the male or female
2 reproductive system defined by the failure to achieve a pregnancy after 12 months or more of
3 regular unprotected sexual intercourse;”¹ and
4

5 Whereas, this definition excludes people with infertility who do not have heterosexual
6 intercourse, who are interested in parenting alone, or who have clear and immediate medical or
7 physiologic indications for fertility treatment; and
8

9 Whereas, AMA Code of Medical Ethics 4.2.1 on “Assisted Reproductive Technology” states in
10 part that “Physicians who offer assisted reproductive services should... not discriminate against
11 patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the
12 basis of race, socioeconomic status, or sexual orientation or gender identity;”³ and
13

14 Whereas, AMA policy H-510.984 on “Infertility Benefits for Veterans” states in part that “7. Our
15 AMA supports expansion of reproductive health insurance coverage to all active-duty service
16 members and veterans eligible for medical care regardless of service-connected disability,
17 marital status, gender or sexual orientation;”⁴ and
18

19 Whereas, AMA policy H-185.926 also “supports: (1) insurance coverage for fertility treatments
20 regardless of marital status or sexual orientation when insurance provides coverage
21 for fertility treatments; and (2) local and state efforts to promote reproductive health insurance
22 coverage regardless of marital status or sexual orientation when insurance provides coverage
23 for fertility treatments;”⁵ therefore be it
24

25 RESOLVED, that our American Medical Association amend policy H-420.952 “Recognition of
26 Infertility as a Disease” by addition, to state:

- 27 1. Our AMA supports the World Health Organization’s designation of infertility as a
28 disease state with multiple etiologies requiring a range of interventions to advance
29 fertility treatment and prevention.
30 2. Our AMA also supports the American Society for Reproductive Medicine’s definition
31 of infertility as (a) the inability to achieve a successful pregnancy based on a
32 patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic
33 testing, or any combination of those factors; (b) the need for medical intervention,
34 including, but not limited to, the use of donor gametes or donor embryos in order to
35 achieve a successful pregnancy either as an individual or with a partner; and (c) in
36 patients having regular unprotected intercourse and without any known etiology for
37 either partner suggestive of impaired reproductive ability, evaluation should be
38 evaluated at 12 months when the female partner is under 35 years of age and at 6
39 months when the female partner is 35 years of age or older. Nothing in this definition

1 shall be used to deny or delay treatment to any individual, regardless of relationship
2 status or sexual orientation. (Modify Current HOD Policy); and be it further
3

4 RESOLVED, that our AMA work with other interested organizations to communicate with third-
5 party payers that discrimination in coverage of fertility services on the basis of marital status or
6 sexual orientation cannot be justified (Directive to Take Action); and be it further
7

8 RESOLVED, that our AMA reaffirm policy H-510.984 “Infertility Benefits for Veterans,” (Reaffirm
9 HOD Policy); and be it further
10

11 RESOLVED, that our AMA report back on this issue at I-25. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organization’s designation **of infertility** as a disease state with multiple etiologies requiring a range **of** interventions to advance fertility treatment and prevention. [Res. 518, A-17]

AMA Code of Medical Ethics 4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover **assisted reproductive** services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

“**Assisted reproductive technology**” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients.

Physicians who offer **assisted reproductive** services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

AMA Principles of Medical Ethics: I,V,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

[Issued: 2016]

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of **Veterans** Affairs (VA) from covering in vitro fertilization (IVF) costs **for veterans** who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs **for veterans** who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care **benefits** provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address **infertility** due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of **infertility** in servicewomen may be linked to military service, and which approaches might reduce the burden of **infertility** among service women.
6. Our AMA will work with interested organizations to encourage TRICARE to cover: (1) fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) **for** medical indications, **for** active-duty military personnel and other individuals covered by TRICARE; and (2) gamete preservation **for** active-duty military personnel and activated reservist military personnel.
7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and **veterans** eligible **for** medical care regardless of service-connected disability, marital status, gender or sexual orientation.

[CMS Rep.01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22; Appended: Res.801, I-22]

Reproductive Health Insurance Coverage H-185.926

Our AMA supports: (1) **insurance coverage** for fertility treatments regardless of marital status or sexual orientation when **insurance** provides **coverage** for fertility treatments; and (2) local and state efforts to promote **reproductive health insurance coverage** regardless of marital status or sexual orientation when **insurance** provides **coverage** for fertility treatments. [Res. 804, I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(1-24)

Introduced by: Minority Affairs Section

Subject: Opposition to the Deceptive Relocation of Migrants and Asylum Seekers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, state governors have spent billions to inappropriately relocate over 100,000 migrants
2 out of state without food, housing, or other basic necessities and without accounting for health
3 needs or weather conditions, raising major humanitarian concerns¹⁻²; and
4

5 Whereas, migrants report being falsely promised expedited work papers, job offers, free
6 housing, education for their children, and free legal assistance, while others have been
7 manipulated due to their fear of deportation and been either incorrectly informed or completely
8 uninformed where they are being relocated³; and
9

10 Whereas, a child relocated from Texas to Chicago died en route due to previous illness, despite
11 claims that “no passenger presented with medical concerns”⁴; and
12

13 Whereas, a security employee monitoring buses transporting migrants called their conditions
14 “disgusting” and “inhumane”, describing lack of facilities for disposal of menstrual products,
15 diapers, and human waste⁵; and
16

17 Whereas, a migrant unknowingly bussed to Philadelphia from Texas reported that her 10 year-
18 old daughter had to be hospitalized for acute dehydration and high fever after the journey⁶; and
19

20 Whereas, despite inadequate funds and personnel, volunteer physicians and medical students
21 serving thousands of bussed migrants in Chicago have treated a wide range of medical
22 emergencies, including infected skin lacerations, stabbings, and miscarriages⁷; therefore be it
23

24 RESOLVED, that our American Medical Association oppose the relocation of migrants and
25 asylum-seekers by state or federal authorities without timely and appropriate resources to meet
26 travelers' needs, especially when deceptive or coercive practices are used (New HOD Policy);
27 and be it further
28

29 RESOLVED, that our AMA support state and federal efforts to protect the health and safety of
30 traveling migrants and asylum-seekers and investigate possible abuse and human rights
31 violations. (New HOD Policy)

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

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RELEVANT AMA POLICY

Addressing Immigrant Health Disparities H-350-957

(1) Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and supports legislation and policies that address the unique health needs of refugees.

(2) Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. [Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmed: A-19; Appended: Res. 423, A-19; Reaffirmed: I-19]

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

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. [Res. 002, A-17 Appended: Res. 218, A-21 Reaffirmed: Res. 234, A-22]

Opposing the Detention of Migrant Children H-60.906

1. Our American Medical Association opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care.
2. Our AMA supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children.
3. Our AMA urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-24)

Introduced by: Minority Affairs Section

Subject: Supporting Diversity in Research

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, 25 million Americans with low English proficiency (LEP) are regularly excluded
2 from medical research, limiting sample diversity and generalizability of results¹⁻³⁷; and
3

4 Whereas, 20% of all clinical trials require English proficiency³³; and
5

6 Whereas, barriers to greater participation of patients with LEP in medical research include
7 unclear, outdated, and inconsistent federal and institutional guidance, differences in
8 certification of non-medical interpreters and use of uncertified interpreters leading to errors
9 and downstream costs, and time and funds required for translated consent forms and
10 interpretation during study visits³³⁻⁵¹; and
11

12 Whereas, patients who are Deaf and Hard of Hearing are frequently excluded from clinical
13 trials and report that their greatest barrier to recruitment and participation is the lack of
14 communication accessibility^{53,54}; and
15

16 Whereas, federal agencies oversee 2,300 Institutional Review Boards (IRBs) at 1,800
17 institutions and organizations nationwide⁴³; and
18

19 Whereas, recent federal efforts have focused on improving diversity in clinical research but
20 have not yet addressed the use of interpretation⁵²; and
21

22 Whereas, the U.S. Department of Health & Human Services Office of Human Research
23 Protection's (OHRP) guidance on "Informed Consent of Subjects Who Do Not Speak English"
24 has not been updated in nearly 30 years⁵²; therefore be it
25

26 RESOLVED, that our American Medical Association support the use of language interpreters
27 and translators in clinical and medical research participation to promote equitable data collection
28 and outcomes (New HOD Policy); and be it further
29

30 RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to
31 develop and publish transparent guidelines for interpreter services to ensure appropriate
32 enrollment and ongoing participation of medical and clinical research participants with Limited
33 English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further
34

35 RESOLVED, that our AMA advocate for the Department of Health and Human Services and
36 Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent
37 of Subjects Who Do Not Speak English (1995)" (Directive to Take Action); and be it further
38

39 RESOLVED, that our AMA support the creation of a federal standard upon which individual
40 Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

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

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RELEVANT AMA POLICY

Allergen Labeling on Food Packaging H-150.924

Our AMA encourages food manufacturers to pursue more obvious packaging distinctions between products that contain the most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens. [Res. 918, I-18]

Preventing Allergic Reactions in Food Service Establishments D-440.932

Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.[Res. 416, A-15]

Increasing Awareness of Nutritional Information and Ingredient Lists H-150.948

Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items. [Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

Product Date Labels H-150.926

Our AMA will support federal standardization of date labels on food products to ensure that the labels address safety concerns. [Res. 421, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-24)

Introduced by: American Psychiatric Association, Minority Affairs Section, Oklahoma

Subject: Missing and Murdered Black Women and Girls

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, in the United States, Black people comprise 13 percent of the population, but
- 2 represent more than 33 percent of the nearly 550,000 people who were reported missing in
- 3 2022; and
- 4
- 5 Whereas, Black women comprise 7 percent of the US population yet nearly 20 percent of all
- 6 missing persons cases; and
- 7
- 8 Whereas, Black women and girls less than 20 years of age comprise up to 2% of the population
- 9 but represent more than 15 percent of missing persons; and
- 10
- 11 Whereas, in 2022, the National Crime Information Center reported more than 140,000 Black
- 12 children age 17 and younger went missing for at least some period, including more than 77,000
- 13 girls, approximately 39% of missing children in the U.S. that year; and
- 14
- 15 Whereas, Black women making up 40 percent of sex trafficking survivors; and
- 16
- 17 Whereas, more than 40 percent of Black women have experienced intimate partner violence in
- 18 their lifetimes and are nearly three times as likely than white women to be killed by an intimate
- 19 partner; and
- 20
- 21 Whereas, the homicide rates among Black women in the U.S. are disproportionately high
- 22 compared to their peers and Black women are murdered at younger ages and higher rates; and
- 23
- 24 Whereas, the number of unsolved homicides of Black women and girls rose by 89% in 2020 and
- 25 2021 compared with 2018 and 2019, a far bigger increase than any other demographic group
- 26 according to a survey of 21 U.S. cities by the Wall Street Journal; and
- 27
- 28 Whereas, missing person cases involving Black women and girls stay open four times longer
- 29 than their white peers; and
- 30
- 31 Whereas, all studies demonstrate that Black women and girls receive significantly less media
- 32 attention at the outset to garner media coverage; and
- 33
- 34 Whereas, Black women and girls are less likely to be the subject of a single news story and a
- 35 high-profile case that dominates the news, or receive extensive news coverage referred to as a
- 36 "signal crime"; and
- 37
- 38 Whereas, signal crimes are much more visible than cases that only receive a news story or two,
- 39 and thus are likely to have a greater influence on the perceptions and beliefs of viewers and
- 40 readers; and

1 Whereas, Scripps Howard News Service analyzed CNN and Associated Press (AP) news
2 reports pertaining to child abductions from 2000 to 2004. The study found that the 162 AP
3 stories and 43 CNN reports dramatically overrepresented white children; and
4

5 Whereas, Seong-Jae Min and John C. Feaster found that missing black children were
6 underrepresented in their sample of 161 nationally broadcast television news segments when
7 compared to the racial composition of the overall missing children population; and
8

9 Whereas, the Black and Missing Foundation reports that missing minority children are often
10 initially classified as “runaways” — which prevents them from being eligible for an Amber Alert
11 — and minority adults who go missing are often associated with “criminal involvement,”
12 including gangs and drugs, thus lowering the odds of a successful outcome; and
13

14 Whereas, in 2023, Minnesota became the first state to create an Office of Missing and
15 Murdered Black Women and Girls, which will receive annual state funding to support families
16 and communities and help solve open and cold missing persons cases among Black women
17 and girls; and
18

19 Whereas, Illinois followed Minnesota in implementing a task force to look into disparities around
20 violence against Black women and girls; and
21

22 Whereas, Wisconsin and Missouri have followed Minnesota in introducing legislation to create a
23 Task Force on Missing and Murdered Black Women and Girls Office; and
24

25 Whereas, in 2024 California enacted an Ebony Alert, an emergency alert system, upon request
26 from local law enforcement when a Black youth or young Black woman, between the ages of 12
27 and 25, is reported missing “under unexplained or suspicious circumstances,” is considered “at
28 risk, developmentally disabled, or cognitively impaired” or has been abducted; and
29

30 Whereas, members of the United States House of Representatives have followed Minnesota’s
31 blueprint and introduced legislation to create a National Office on Missing and Murdered Black
32 Women and Girls; therefore be it
33

34 RESOLVED, that our American Medical Association advocate that the United States
35 Department of Justice collect data on missing persons and homicide cases involving Black
36 women and girls, including the total number of cases, the rate at which the cases are solved,
37 the length of time the cases remain open, and a comparison to similar cases involving different
38 demographic groups (Directive to Take Action); and be it further
39

40 RESOLVED, that our AMA advocate for the United States Department of Justice, legislators,
41 and other stakeholders to collect data on Amber Alerts, including the total number of Amber
42 Alerts issued, aggregated by the child's race and sex (Directive to Take Action); and be it further
43

44 RESOLVED, that our AMA encourage state medical societies to work with legislators,
45 advocates, and other stakeholders to establish equity in policy and practices related to missing
46 and murdered black women and girls. (New HOD Policy)

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

Received: 9/24/2024

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RELEVANT AMA POLICY

Missing and Murdered Indigenous Persons H-350.938

Our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere. [Res. 411, A-24]

Missing Children Identification H-60.996

1. Our American Medical Association supports development of a means of identifying children.
2. Our AMA supports education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child.[Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-24)

Introduced by: Kansas

Subject: Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, civil causes of action removed from allegations of breach in standard of care can
2 drive a wedge between patient and physicians, increase costs, and fail to yield improved care
3 and outcomes for patients; and
4
5 Whereas, adding new civil causes of actions against physicians to enforce legislative policy may
6 conflict with a physician's duty to make treatment decisions that meet the accepted standard of
7 care for each individual patient and their specific needs; and
8
9 Whereas, utilizing the threat of civil lawsuits as an enhanced enforcement mechanism for
10 legislative policy is unnecessary and encourages more costly litigation, which has significant
11 emotional, financial, and relational consequences for patients, physicians, and the healthcare
12 system as a whole; and
13
14 Whereas, adequate remedies already exist to hold physicians accountable for actions that fall
15 below the standard of care; and
16
17 Whereas, the American Medical Association is committed to advocating for the best interests of
18 patients and physicians; state law provides a cause of action for patients to obtain
19 compensation for injuries caused by medical negligence, and physicians are subject to
20 significant consequences for failure to comply with statutory requirements, including loss of
21 license to practice; therefore be it
22
23 RESOLVED, that our American Medical Association affirms that civil causes of action in
24 healthcare should be limited to causes of action that address alleged violations of a physician's
25 duty to meet the standard of care in the treatment of patients. (New HOD Policy)

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

Received: 9/24/2024